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**From support worker to professional qualification**

**The work role transition to Registered Nurse of student nurses who were formerly employed as Health Care Assistants**

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# **From support worker to professional qualification: the work role transition to Registered Nurse of student nurses who were formerly employed as Health Care Assistants**

**By Victoria Anne Arrowsmith**

A thesis submitted to the University of London  
for the Degree of Doctor of Philosophy

Florence Nightingale Faculty of Nursing and Midwifery  
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## Abstract

In spite of national and international policy encouraging assistant nurses to become Registered Nurses (RNs), the work role transition they experience has attracted little attention from researchers. The present study addressed this gap, adopting a mixed methods, cross-sectional, sequential approach. Qualitative approaches were needed to develop core understandings of work role transitions and quantitative approaches for statistical measures to outline changes over time and influences on transitions. The dominant approach was qualitative, sequencing the qualitative to follow the quantitative data collection. The components were analysed separately up to the point of interface and the core qualitative component provided the mechanism for reporting the results.

Three cohorts of student nurses at two universities, from academic years 1, 2 and 3, and with prior Health Care Assistant (HCA) experience, were surveyed then interviewed at the beginning and end of their academic years. It was found that students, clinicians and policy makers assume and expect that prior HCA experience facilitates students' pathway to RN. Findings indicate that the former role and workplace experience do not automatically facilitate change and transition.

A model of transition is presented from assistant worker to professional qualification. Students disconnected from their former work role, re-visioning old values and perceptions and finding that the student/RN role required different ways of thinking and working. They moved from a skills task focus to a whole-task approach. Students experienced role change shock as they found that prior experience did not automatically equip them for their placements and could constrain as much as facilitate their transitions. They entered a betwixt and between stage of uncertainty and discomfort while learning to act out the student role to the satisfaction of audiences of practitioners, educationalists and patients. Students changed and developed, clinically, professionally, academically and personally, becoming a "reconstituted" person before inclusion in the profession. The combination of transitions and dramaturgical, theoretical and analytical approaches explains the pattern and experiences of transition. The journey of transition cannot be reversed because, once educated to be a nurse, the traits deemed desirable by the profession are made to "stick" and exert their influence long after initial education. The support worker becomes professionally qualified – the transition from HCA to student and neophyte RN is completed.

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## Glossary

Abbreviation	Full Term	Explanation of term
CFP	Common Foundation Programme	The core element that underpins each nursing branch and is shared by all nursing students in the UK. It introduces students to the four branches (Adult, Mental Health, Learning Disabilities, Children's nursing) but also focuses on a range of subjects within and applied to nursing that are common to all branches
DH	Department of Health	The Department of the United Kingdom government with responsibility for government policy for England on health, social care and the National Health Service (the other countries in the UK have their own agencies and arrangements)
DipHE	Diploma in Higher Education	A higher education qualification in the UK awarded by a university or other higher education institution. The diploma certifies that a student has achieved a minimum standard after two years' full-time education or, in the case of nursing, three years
EU	European Union	A group of European countries that act together in political and economic matters
GP	General Practitioner	A doctor who treats the people who live in the local area and treats conditions that do not need a hospital visit
HCA	Health Care Assistant	An assistant nurse. The title was established in the National Health Service and Community Care Act (1990) in the United Kingdom
NHS	National Health Service	The publically funded health care system in England (the term in Scotland is NHS Scotland, in Wales NHS Wales and in Northern Ireland Health and Social Care Northern Ireland)
NMC	Nursing & Midwifery Council	The nurses and midwives register for England, Wales, Scotland and Northern Ireland, maintained in order to protect the public
RN	Registered Nurse	A person trained in nursing, meeting prescribed standards of education and clinical competence and registered/licensed to practise nursing
UK	United Kingdom	Country that consists of England, Scotland, Wales and Northern Ireland
UKCC	United Kingdom Central Council	The Council was established in 1983 and renamed the Nursing and Midwifery Council in 2002. Core functions were to maintain the register of UK nurses, midwives and health visitors, provide guidance to registrants and handle cases of professional misconduct. At the same time national boards were created in each of the UK countries. Their function was to monitor nursing and midwifery education courses and to maintain training records of students on these courses.
USA	United States of America	Country in North America

# Chapter 1 Background

## 1.1 Introduction

Each year thousands of students embark on programmes of preparation for registration as a nurse. Among these aspiring nurses some have experience as an assistant nurse. In the United Kingdom (UK) most are known as Health Care Assistants (HCAs), and as student nurses they are required to make the transition from the role of assistant nurse to professionally qualified Registered Nurse (RN). Transitions involve change, or passage, as individuals move from one stage to another (Kralik *et al.* 2006) and their importance lies in the ability to unite the individual, their context and institutions in which they work and study (Nicholson & West 1989, Gunz & Peiperl 2007). This study seeks to develop theoretical and empirical understandings of work role transitions experienced by student nurses in the UK with past HCA work role experience as they study to take up the role of RN.

In this chapter, which sets out the background to this study, Section 1.2 presents the social and political context of health care work, Section 1.3 describes the HCA work role context, and Section 1.4 introduces the aims and objectives of this study. Section 1.5 concludes the chapter.

## 1.2 The social and political context of health care

By the end of the first decade of the millennium, worsening global economic conditions resulted in significant borrowing by the UK government. In February 2015, public sector net borrowing was £6.9 billion, meaning that the public sector's spending was more than its income. Between April 2014 and February 2015 the public sector borrowed £81.8 billion and this impacted on health care provision, which is funded from the public purse (Office for National Statistics 2015). Historically there have been many experiences of nursing costs and budgets being targeted for savings during times of austerity, including nurse education (Buchan & Seccombe 2009). Nurses are the largest group in the health care sector and are strongly affected by budget-balancing attempts. They are the easiest and fastest way to balance the books, achievable through cutting back their numbers (Alameddine *et al.* 2012). Budget reductions impact detrimentally on student nurses, not only affecting the numbers of pre-registration training and education places available, but also the numbers of RNs and other professionals available to support their learning in clinical practice.

The number of people employed in hospital and community health services in England alone is large. In September 2014 a head count found there were 1,397,692 employees and, according to the Health and Social Care Information Centre (Bedford & Horan 2015), this is 23,527 (1.7%) more than in September 2013 and 126,832 (10.1%) more than in 2004, an average annual increase of 1%. It has been estimated that more than half the workforce are health care professionals, including doctors, nurses, midwives, health care scientists, pharmacists and a wide range of allied health professionals (DH 2010a). The Health and Social Care Information Centre (2015) reported that 370,327 qualified nurses, 53,140 HCAs and 70,380 assistant nurses/auxiliary staff are employed in the NHS alone. In 2013 Cavendish reported that over half the HCA workforce worked in the NHS acute sector; their average age was 45 years and 84% were recorded as female. Fifteen per cent were from black and minority ethnic groups and the average number of years in post was 4.1. Turnover was recorded at 14% and 56% were recorded as being paid at Band 2, Agenda for Change, i.e. between £14,294 and £17,425 per annum (Cavendish 2013).

In addition to those working in the NHS there are about 1.6 million people employed in the adult social care workforce, of whom fewer than one in ten hold a professional qualification (DH 2010a). There are also management and administration staff and structures within health and social care systems.

The management and administration of the NHS has been subject to numerous changes since its inception in 1946. The latest, and perhaps most radical, reorganisation of health services, (Walshe 2010) presents a picture of tremendous change for those working within the organisation. Changes in England, and related changes in Wales, Scotland and Northern Ireland, include: Strategic Health Authorities and Primary Care Trusts being abolished; GP consortiums to handle health care commissioning; public health responsibility handed over to local authorities; the Department of Health stripped of many functions and independent NHS Boards created; NHS Trusts encouraged to become Foundation Trusts; a restructuring of the health care regulators (Walshe 2010). Alongside structural changes there have recently been the highly publicised failings of the NHS in England. In particular, concerns about the failure of care at the Mid Staffordshire NHS Trust prompted a public inquiry. Negative aspects of culture were outlined in the ensuing report: a lack of openness to criticism; a lack of consideration for patients;

defensiveness. Unsurprisingly, a change in culture in this and other NHS organisations has been recommended (Francis 2013, p. 65). It is against this challenging and tumultuous backdrop of the NHS that HCAs, student nurses, RNs, as well as all who support students, work and deliver care.

### **1.3 The HCA work role context**

Nursing assistants achieved formal recognition in 1955 through the establishment of the role of nursing auxiliary (Thornley 2000, McKenna *et al.* 2004, Griffiths & Robinson 2010). In 1990 the NHS and Community Care Act introduced the new grade of Health Care Assistant, which gradually incorporated nursing auxiliaries. With the advent of “Project 2000”, nurse training shifted from an apprenticeship model to one rooted in higher education. This resulted in reduced opportunities for students to act as nurse supporters and the HCA grade was explicitly seen as the replacement for student nurses (Kessler *et al.* 2010).

The range of jobs within the field of nursing is large, offering considerable scope for change of work role, not just within one segment of nursing practice but between them (NHS Careers 2015). Government policy over years has recommended developing the skills and careers of those already employed in delivering services (DH 2010a). It assumes “local” recruitment and perhaps increased levels of retention. Intuition suggests that improving on retention and stability benefits patients, staff and the organisation (Buchan 2010). However, turnover is a complex topic and there is little published data or information, and much of that which is available is derived from the USA (Buchan 2010). However, in the UK the development of existing staff has long been supported by governments, and incentives have been provided for employers to invest in their workforce (DH 2010b), including assistant nurses. Moreover, concerns exist on appropriate recruitment and successful retention of nurses (Francis 2013, RCN 2013). One solution identified has been to support assistant nurses to become nurses (DH 2006, DH 2010b, Cavendish 2013).

Internationally the trend of facilitating assistant nurses to become nurses is also evident. For example, in the USA “Certified Medical Assistants” and “Psychiatric Aids” (Nursing Assistant Guides 2015) are employed. These roles are seen as an opportunity to gain, in part, the necessary educational qualifications to become an RN. Likewise in the EU pathways for assistant nurses to become RNs are available. In 2014 a report to the European Union Commission (Braeseke *et al.* 2014) presented data from 14 participating countries. The aim was to provide a

Europe-wide exchange about educational standards and legal regulations of employment of assistant staff in the health care sector. The 14 participating countries represented a broad range of different countries in terms of old and new member states, geographical locations, small and large states and financing and organisation of health care systems. It found that only three states had unregulated nurses' assistants (Ireland, Switzerland and the UK). Training for HCAs varies from between 8–12 months (Denmark) to four years (Czech Republic and Slovenia) and only Bulgaria and the UK do not have an officially recognised exam for HCAs. In the UK it is planned from 2015 that all new HCA starts will achieve the Certificate in Healthcare in England before working unsupervised. However, all EU countries express a commitment to developing HCAs and facilitating access to RN education and training, and this was an important recommendation arising from the report (Braeseke *et al.* 2014).

In the UK a policy framework has been established to support the career development of existing employees: the NHS Career Framework (Skills for Health 2011a). It is reinforced through Agenda for Change, the NHS pay system which lays out a nine-tier framework for career progression. The purpose of the career framework is to enable skills escalation as well as to provide opportunities for individuals to develop their careers. At the lower end there have been increases in the number of new posts at Bands 3 and 4. Posts in both bands include HCAs and Band 3 and 4 posts also include the development of Assistant Practitioner roles (Skills for Health 2011a). Band 4 posts occupy a position just below the level of professionally qualified staff, such as nurses, physiotherapists, occupational therapists and radiographers. These Band 5 practitioners are regulated by their professional body while currently those below are accountable to themselves, their employer and the people they serve (Skills for Health 2011a) but not to a statutory regulatory body. This framework of career progression provides a pathway for HCAs to progress to a professional qualification as well as a route for RNs to progress their careers. In addition, the demand for HCA career development from the workers themselves is considerable. An annual survey conducted by UNISON (2010) found that in the 25–34 years age group, 59% of HCAs were “very interested” in professional training. This finding is supported by Kessler *et al.* (2010) who, in a large study of HCAs in hospital settings, also found that many aspired to become a nurse.

Some HCAs enter programmes of preparation for registration seconded by employers (Gould *et al.* 2004) while others use their experience, in part, as a stepping stone into pre-registration nursing programmes. Programmes prepare students for registration in adult, mental health, learning disabilities or children's nursing. The numbers of students undertaking pre-registration nurse education programmes are difficult to ascertain, being a part of the "ongoing and significant gaps in nursing workforce data" (Buchan & Seccombe 2012, p. 1). However, in the UK in 2012–13 the total number of new students, including former HCAs, was estimated to be 23,380 (Buchan & Seccombe 2012). Many pre-registration programmes include former HCAs, although data about them and their demographics is sparse. One programme is comprised entirely of students with prior HCA experience (The Open University 2011). Moreover, following the public inquiry into the appalling care at the Mid Staffordshire Hospital the Francis Report recommended that experience as an HCA should be a prerequisite to entry into the nursing profession (Francis 2013). Following the Francis Inquiry the Cavendish Review (2013) recommended that Health Education England and its Local Education and Training Boards develop bridging programmes into pre-registration nursing for support staff workers. It also recommended that consideration be given to providing a fast track for experienced workers on degree programmes. Since then pilot pre-nursing experience projects have been established across England by Health Education England and early evaluations suggest they are successful (Lovegrove and Griffin 2015). These are paid placements where, it is claimed, individuals can build their experience to better prepare them for university courses (HEE 2015). Moreover, it is recommended that to achieve cost neutrality, future health care experience is offered through filling existing vacant HCA posts and training provided through undertaking the Certificate in Health Care, which is recommended for all bands of health care workers.

Whatever the gaps in data and whatever the changes in access to pre-registration nursing, the work role change from assistant to RN is an enduring one, one backed internationally by political and individual desire, and one that is likely to persist. Currently in the UK, government policy is backing plans to provide HCA experience for student nurses before they begin programmes of preparation for registration. It is timely to examine the issues and develop understanding of this group of student nurses.



### 1.3.1 The changing HCA work role

In recent years there has been an increased emphasis on targets by governments intent on improving care in the NHS. A focus on efficient throughput of patients has resulted in many nurses spending large amounts of time dealing with the complexities of admissions and discharges. They are also required to spend time auditing a variety of aspects of patient care and of practice environments (Kessler *et al.* 2010). Such is the pressure on practising nurses that in 2013 the RCN was prompted to produce a report which found that nurses now “see more patients with greater need while at the same time have fewer staff to look after them” and believes “there are now red lights flashing across the UK warning we are heading for a nursing shortage that could have serious implications for health services and patients” (RCN 2013, p. 2). As a result of the implementation of the NHS Career Development Framework, tasks formerly designated as part of the role of the RN have been delegated downwards as well as upwards (Waters 2011). Tasks that are deemed simple and/or routine and low risk, and which can be performed safely with appropriate training, and under supervision, are those most likely to be delegated. Many are taken up by HCAs and more recently by Assistant Practitioners working at Band 4 (Waters 2011).

Delegation of these tasks to lower-band workers in principle enables higher-band professionally qualified staff, such as nurses, to extend the scope of their practice and take on advanced roles (Waters 2011). Also in principle, delegation allows the professionally qualified practitioner additional time to take forward these advanced roles. This role extension, or extended scope of practice, or role enhancement, allows practitioners such as nurses to take on tasks and roles formerly the domain of doctors. The implementation of the EU Junior Doctors Working Time Directive, taking effect in the NHS in 2009 (Kessler *et al.* 2010), has hastened this process. As a result a plethora of nursing roles has emerged since 2006, the titles of which include: Nurse Practitioner; Clinical Nurse Specialist and Nurse Consultant (Kessler *et al.* 2010). Roles which have emerged in primary and secondary health care settings are as diverse as Occupational Health Specialist, Cancer Information Specialist, Nurse Consultant Emergency Care and Clinical Nurse Specialist, Cystic Fibrosis and Nutrition (RCN 2005, RCN 2012a).

As nurses' work roles have changed over recent years so has the role of HCAs, and it now includes aspects of care that were once the responsibility of nurses (Kessler *et al.* 2010, UNISON

2010). Key tasks include the fundamental personal care that patients and clients require to meet self-care deficits (Kessler *et al.* 2010), including making beds and bathing people. HCAs' duties can also include taking blood samples and monitoring and recording patients' observations, through to more advanced tasks such as carrying out venous cannulation, catheterisation and complex dressings (UNISON 2010). Many of these tasks, though not all, are undertaken as part of hospital in-patient care (Kessler *et al.* 2010), and private training companies operating outside the NHS now advertise a wide range of skills that HCAs can be trained to perform in a range of settings. These include: administration of medications; second-checking controlled drugs; recognising and responding to the deteriorating adult; improving nutrition and hydration; injection technique and immunisation training including flu and vitamin B12; assisting in medical procedures; wound management; skills training for HCAs in GP surgeries (M&K Updates 2013); and others. Additionally, nursing tasks are also performed by a range of care assistants working in community settings, including residential and nursing homes, as well as patients' and clients' own homes (Reed Recruitment 2015).

### **1.3.2 From HCA to student nurse**

The wide range of tasks which HCAs can perform, the wide range of practice environments they work in, and the amounts of trained nurse supervision available to them, raises interesting questions about transitions during studentship. The role of nurses' assistants in the UK was, and still is, unregulated. Lack of regulation entails little control over entry to employment, competencies, education and standardisation of roles, and raises concerns over patient safety and protection of the public (Griffiths & Robinson 2010). On the other hand RNs are required to adhere to the standards of conduct, performance and ethics laid down by their regulatory body, the Nursing and Midwifery Council. The Council lays down standards that all RNs must adhere to in the course of their everyday work with patients and clients (NMC 2015a). In its 25 standards ('The Code') it stipulates the professional behaviours and attitudes required of a nurse. This includes the requirement to support students and colleagues learning to help them develop professional competence and confidence. The standards also extend beyond the immediate workplace, for example, the NMC (2015b) offers guidance on how The Code can be breached through the use of social networks. The role of the professional RN is therefore demanding and complex. For HCAs, who are presently unregulated, and whose duties are led and supervised by nurses, the move to student nurse with a view to becoming a registrant is arguably a large step

which requires the student and aspiring nurse *to be* a certain type of person and behave in particular ways. Moreover, this step also requires the aspiring registrant to meet the academic standards required of a nurse.

The major change in nurse education in the early 1990s introduced “Project 2000”, bringing with it the full integration of former schools of nursing into higher education institutions. Since then, and from 2013, the award of a degree has been the minimum educational preparation that students of nursing must achieve before becoming eligible to apply for registration with the Nursing and Midwifery Council (NMC 2010). By 2016 all nurses entering the register for the first time must be Bachelors degree level graduates (NMC 2015c), presenting the aspiring HCA turned student nurse with academic as well as professional challenges.

## **1.4 Aims and objectives**

This study draws on existing transitions and role theory to explore the transition of student nurses with prior HCA experience to RN. It aimed to contribute to knowledge in the following ways:

First, it aimed to contribute to theoretical knowledge on work role transitions. As detailed in Chapter 2, a wide range of general transitions theories exist. However, there are gaps in the literature in theories of transition from support worker to professionally qualified worker, both within nursing and across other disciplines. Common to many professions, for example, teaching (Graves 2012), social work and occupational therapy (Audit Commission 2012) and nursing (Skills for Health 2011b), the use of assistant workers is increasing, opening the possibility of greater numbers of experienced workers seeking career development and professional qualifications, with the ensuing need to understand transitions. HCAs provide a good exemplar of moving from experienced worker to professionally qualified member of the workforce. They are geographically widespread, work in diverse fields of nursing practice and undergo a statutory period of education and training prior to statutory registration during which the process and outcomes of transition can be studied.

Second, the experiences of former HCAs can be documented and explored to develop a detailed understanding of their journey to registration. Some limited literature exists on their studentship (see Roberts 2006, Wood 2006, Brennan & McSherry 2007), with most being evaluations of

programmes (Kevern *et al.* 1999; Gould *et al.* 2004, Gould & Fontela 2006, Swallow *et al.* 2007, Southgate & Felstead 2010). A detailed examination of students' experiences will add to this small body of literature.

Third, transitions have implications for the individuals undertaking role change, work organisations and educational establishments. This study aimed to develop a model of transitions which explains the change from support worker to professionally qualified member of the workforce which can be used by stakeholders to facilitate the process.

More specifically, the aim and objectives of this study were:

**Aim:** To understand the work role transition to RN of student nurses who were formerly employed as Health Care Assistants.

**Objectives:**

- 1 To explain students' experiences of the transition process.
- 2 To explore the impact of work role transitions on students.
- 3 To identify and discuss the facilitators and constraints to transition from Health Care Assistant to Registered Nurse.
- 4 To develop a model to explain the transition from Health Care Assistant to Registered Nurse.

Increased knowledge of work role transitions has implications for individuals' careers and for organisations in which they work and study. For employees, both personally and professionally, it is important to understand the work role transitions to facilitate successful movement through the processes that are involved. For employers, increased knowledge and understanding can highlight how to better support workforce and policy development, and for academic institutions increased understanding can facilitate better teaching and support for students. As noted above, this research aimed to appraise and develop an existing model of work role transitions (Brennan & McSherry 2007), and the enhanced model can be used by individuals and the organisations in which they work and study to facilitate the process of transition.

Additionally, if government monies are to be used effectively then increased knowledge and understanding of the factors that enable and constrain work role transitions in health care may not

only improve the quality of individuals' experiences, but also has implications for workforce policy in planning, education and training (Kessler *et al.* 2010). This is particularly important at the present time when, due to the global economic difficulties, great uncertainty exists in health care organisations (Maynard 2010). Training and development budgets are under pressure, and funds for supporting service changes and staff transitions need to be used as wisely and effectively as possible (Baker & McInnes 2015). This thesis presents how the aim and the objectives of this study were addressed.

## **1.5 Conclusion**

This thesis develops theoretical and empirical understandings of the transition from experienced worker to becoming professionally qualified. Student nurses with prior HCA experience provide a good exemplar to study work role transitions because they lack homogeneity as their roles differ both within and between organisations, and they are a geographically diverse group. In addition, they are required to study and train full time for three years to become an RN. During this prescribed period the ebbs and flows, movement and changes involved in the process of transition are available for study. Addressing the transition process through the study aim and objectives provides increased understanding for the individuals who find themselves in transition from experienced worker to professionally qualified person. Also, and especially during austere times, increased understanding assists educationalists to provide optimum academic support and for employers it assists provision of enhanced support in the workplace, for the workforce and ultimately for the care of patients and clients.

## **Chapter 2 Work role transitions: theories and perspectives**

### **2.1 Introduction**

Interest in this study was first stimulated by wanting to know more about student nurses with prior health care work experience allied to nursing, sometimes of many years, and how they made the transition to professionally qualified nurses. Precisely how did they accomplish the change and what were their experiences, when, as discussed in Chapter 1 increasing numbers perform the care and tasks that were once the domain of the RN? What supported and what stood in the way of making the transition, and did their prior experience help? The initial broad review of the literature presented in this chapter formed the basis for developing an understanding of the field of study. It was also the precursor for a systematic review of the literature which was undertaken to further inform this study's aims, objectives and development. This systematic review is presented in Chapter 3.

There are seven sections in this chapter. Section 2.2 discusses functionalist and interactionist sociological perspectives. Section 2.3 discusses professional socialisation theories and Section 2.4 role theory. Transition theories are discussed in Section 2.5 and studies of the transition from HCA to RN are the subject of Section 2.6. The chapter is concluded in Section 2.7.

### **2.2 Functionalist and interactionist perspectives**

Functionalism and interactionism are two traditional major sociological perspectives which have influenced many studies of socialisation and roles (Abercrombie *et al.* 2006, Smith 2011). Key points in the functionalist perspective include that the various parts of society are interrelated and taken together they form a complete system. Behaviour in society is structured and relationships between members of society are organised in terms of rules. Rules stipulate how people are expected to behave and can be formal, for example, laws, or informal norms which provide specific guidance on how to act in particular situations, for example, how to dress at a funeral (Haralambos & Holborn 2013).

The functionalist perspective holds that roles are more or less fixed positions within society to which are attached certain expectations and demands. These are enforced by sanctions which can be either positive or negative. For example, a teacher or parent or employer may express

approval or disapproval of “learned responses” that are communicated during the process of socialisation into a role. Functionalists see institutions as arising in society because they fulfil a need. They assume a division of labour which expresses the state of development of a society, with more complex societies having greater differentiation in their workforce (Conway 1978). Institutions are embodied in individual experience by means of role, and by playing roles the individual participates in the social world. By internalising these roles the same world becomes subjectively real to that individual (Berger & Luckman 1967). Roles appear as soon as a common stock of knowledge concerning role type is formed. All institutionalised conduct involves role and as soon as actors are typified as role performers their conduct is susceptible to enforcement (Berger & Luckman 1967).

On the other hand, the interactionist perspective differs from functionalism (and Marxism and most feminist theories) in that it focuses on small-scale interventions rather than society as a whole. It does however acknowledge society and its institutions, including those in health care, but views them as framework within which actors make their roles explicit (Conway 1978). Human behaviour is seen as a response to the symbolic acts of others, most notably gestures and speech. People see themselves as objects and this occurs through role taking (Blumer 1969). In order to become objects to themselves people have to see themselves from the outside. They can only do this by placing themselves in the position of others and viewing themselves, or acting towards themselves, from that position. From this perspective it follows that we see ourselves through the ways that others see us. It is a process of meaning making: humans act towards things on the basis of the meanings the things have for them; meaning is derived from the social interaction one has with others; and meanings are handled in and modified through an interpretative process (Blumer 1969). Symbolic interactionism rests on three simple premises: first, that human beings act on the basis of meanings that the things have for them; second, the meaning of such things are derived from or carried out of the social interaction one has with one's fellows; third, these meanings are handled in and modified through an interpretative process used by the person in dealing with the things he encounters (Blumer 1969, p. 2). This three-pronged conceptualisation of symbolic interactionism is the essence and the most widely used explanation of symbolic interactionism (Snow 2001).

Functionalism and interactionalism are important perspectives which can provide explanations of healthcare structures and roles. However, professional socialisation is also relevant to all who aspire to take up professional roles, including student nurses.

## **2.3 Professional socialisation theory**

Professional socialisation is the process by which professionals during their education and training learn the attitudes, values and behaviours required to assume their professional roles (Howkins & Ewans 1999). This is sometimes termed secondary socialisation, taking place after primary socialisation (Berger & Luckman 1967, Jarvis 1995). Primary socialisation occurs during childhood and is the process through which an individual becomes a member of a given society (Berger & Luckmann 1967). Anticipatory socialisation is the collective term used for the values and ideas a student brings with them to professional education and training (Brown *et al.* 2013). These can be a potential source of dissonance during students' subsequent professional socialisation (Brown *et al.* 2013, Maben *et al.* 2006). Anticipatory socialisation is of relevance to students with prior HCA experience who through their past work experiences bring with them views of what a professional nurse is and does. Professional socialisation also involves the recognition of an assumed identity by the outside world as well as individuals recognising that identity within themselves and doing so in a non-deliberate manner. This is a process of internalisation and is the result of successful socialisation (du Toit 1995).

The process of socialisation can be conceptualised as functionalist or interactionist. On the functionalist view it can be seen as the internalisation of social norms, whereby social rules become internal to the individual, being self-imposed with the individual feeling the need to conform. However, it can also be seen as an essential element of social interaction, whereby individuals guide their actions to accord with the expectations of other people (Abercrombie *et al.* 2006). However, the two conceptualisations can be combined and, rather than being viewed as all-powerful and effective processes, can be seen as more tentative, recognising that individuals are rarely totally moulded by the culture of their society (Abercrombie *et al.* 2006). Oleson and Whittaker (1970) suggest that the professional socialisation spans sociology and psychology and the literature results from the merger of three streams of study: occupations, analysis of individual change, and the scrutiny of social institutions.



However professional socialisation has been conceptualised and theorised over the years, a number of influential studies of relevance to health care and nursing have been produced. Classical studies emanate from the 1950s and 60s and their prime focus is medical students (Becker *et al.* 1961, Merton *et al.* 1957). Some studies on student nurses have followed, but there is a dearth of new studies (Stockhausen 2005, Brown *et al.* 2013).

### 2.3.1 Empirical studies

In an early study Merton *et al.* (1957) examined how medical students studying at three schools in the USA learned the behaviours and attitudes of the medical profession. Merton's analysis highlighted the influence of medical school in forging the identities of new doctors. He said:

It is their task to shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act and feel like a physician (Merton *et al.* 1957, p. 7).

Further, Merton *et al.* (1957) state that socialisation refers to learning social roles and it is a process which takes place through interaction with others. As patterns of interaction are only similar and not identical, these variations result in different kinds of doctors emerging from the same social environment, and from the same medical school. His was an essentially functionalist perspective in which he outlined the purpose of existing social arrangements in medical schools.

Also studying medical schools in the USA and their students, Becker *et al.* in 1961 produced a classic study, *Boys in White*. Becker *et al.* took an interactionist perspective, being interested in the processes by which interactions have their socialising effect and also the different ways people respond to their institution. They concluded that medical students come to medical schools to be changed, and their desire to do so is high, but that the effects of institutional participation are complicated. They state that medical students do not simply become what medical schools want them to become. Instead, students':

broad and idealistic notions of what they ought to become are pushed aside as they turn their concern to the immediate business of getting through school ... they become "institutionalized" ... When their participation in the school ends, they give up these concerns realizing that they are no longer of any value (Becker *et al.* 1961, p. 432).

Nonetheless Becker *et al.* see medical school as having some effect and that it transforms the perspectives of idealised practice that students bring with them, rendering it more professional and specific.

Also conducted in the USA, an important early study on nurses and their experiences was published by Kramer (1974). This study reported eight years of research across the USA involving more than 55 interviews with neophyte nurses, diary keeping, and more than 100 formal interviews with senior nurses. From the findings the concept of “reality shock” was suggested: “the startling discovery and reaction to the discovery that school-bred values conflict with work-world values” (Kramer 1974, p.4).

The report presents an anticipatory socialisation programme as a potential solution. It was designed to acquaint nursing students with the reality of nursing practice and how to make their visions of nursing a reality in the future when they practise as nurses. Kramer suggests that learning to become a nurse is achieved through a process of socialisation during which the values and behaviours of the RN are inculcated into the student nurse. She further suggests that these values and behaviours are internalised during induction and training. Like Merton *et al.* (1957) and Becker *et al.* (1961), this suggests a strong role for professional training schools:

Probably more than in any other occupation, the goal of professional training institutions is to inculcate into their aspirants not only the behaviour, but more importantly, the norms and values deemed imperative for survival in the occupation (Kramer 1974, p. 38).

Drawing on studies of medical students as well as nursing students, Kramer suggests that professional socialisation in training schools is role-general rather than role-specific. That is, it pertains to the abstract role of the nurse rather than the specific role the student will one day occupy. Further, the socialisation which takes place in medical and nursing schools prepares students to be medical and nursing students and not physicians and nurses. Kramer goes on to show that the value systems and behaviours which are espoused in schools of nursing are in opposition to those of the workplace. A theoretical framework of “professional and bureaucratic systems of work organisation” is presented which relates to each element: school of nursing and workplace. According to Kramer, the disparity between the elements is the underlying cause of the reality shock experienced when a student qualifies and works as a nurse.

Over a decade later Melia (1987) discussed the occupational socialisation of student nurses in Scotland. A grounded theory approach was taken; theoretical sampling and informal interviews were employed, resulting in 40 hours of tape recordings. The interviews took place over 18

months with nursing students from two colleges who were 8, 18 and 30 months into their training to be an RN. The notion of segmentation was a major organising and theoretical perspective in the analysis of findings, taken from earlier work by Bucher and Strauss ([1961] in Melia, 1987). Melia's study suggested that the two segments of student nurses' training, education and practice, presented two fundamentally different views of the role of the nurse, this echoing Kramer's study. Melia discussed the consequences of socialisation for the individual, the profession and the organisations in which they worked. However, although important, Melia's research was conducted in a different context from that experienced by today's students in the UK. At the time of her study students were counted as part of the health care workforce. Trained staff were accountable to "patients, nursing management, and the medical staff for the standard of care on the ward" (Melia 1987, p. 2).

Melia's study does not discuss the role of a professional regulatory body or of student's academic study experiences. The research was conducted before the establishment in 1983 of the United Kingdom Central Council (UKCC), nurse's regulatory body. This was the predecessor of the NMC, and prior to the implementation of Project 2000, which rooted nurse education within higher education and when student nurses were granted supernumerary work status in practice settings.

A decade after Melia's study, O'Neill *et al.* (1993) conducted a study for the National Board for Nursing and Health Visiting for Northern Ireland, which was set up in conjunction with the UKCC. O'Neill *et al.*'s study, building on Melia's research, drew comparisons between traditional student nurses and those who took a Project 2000 Diploma in Higher Education (DipHE) programme. One hundred and five traditional students and 170 DipHE students took part in a mixed methods evaluation study. Among a comprehensive range of findings, O'Neill and colleagues reported that traditional students saw the role of the nurse as one of care and of specific tasks, whereas the DipHE students referred to "holistic care" and to higher levels of interpersonal skills such as counselling, listening and explaining. The DipHE students also found the content of their academic education more relevant to practice than traditional students, though they did have criticisms of the delivery of the programmes. Findings suggested that professional socialisation, "the rate at which the student acquires the behaviour of the nurse" (O'Neill *et al.* 1993, p. 2), occurred more quickly in traditional students than in Project 2000 students.

Adding further weight to the premise that the process of professional socialisation impacts on student nurses was a study conducted in Brisbane, Australia, by du Toit in 1995. It aimed to find out if professional socialisation leads to the development of a nursing identity. This quantitative research developed a scale to measure professional socialisation and found that students at two universities were highly professionally socialised.

Also in the 1990s a study examining students' clinical experiences was conducted following the implementation of Project 2000 by Gray and Smith (1999). Their study of the professional socialisation of DipHE students took place in Scotland. This was a longitudinal study of students' journey to registration and explored the effects of supernumerary status and mentorship on students in clinical placements. No mention is made of the academic segment of students' pre-registration experiences. However, 17 students took part in a three-year longitudinal study spanning their pre-registration programme. A grounded theory design resulted in the presentation of a six-stage model of professional socialisation, and findings suggested that mentors were "linchpins" in students' development. It was also suggested that students develop intuition earlier in their studies than had been previously reported.

A further study of pre-registration nurses was carried out by Wood, who conducted a study in the UK in 2006 which focused on the process of socialisation of students with prior HCA experience. Eight seconded HCAs from the same cohort of mental health pre-registration nursing students took part in three semi-structured focus group discussions annually over three years. Findings suggested that a unique socialisation processes take place involving the movement from passive to autonomous practice, and dissonance resulted when expectations of being a student were not met.

More recently Brown *et al.* (2013) developed and trialled a tool to measure the effects of the role of clinical teacher on student nurse professional socialisation. The tool, a questionnaire, was developed following interviews then distributed to 58 clinical teachers and 196 students. The findings suggest that clinical teachers are important in the professional socialisation of students, and in particular mature students and those who enter the profession for altruistic reasons.

In summary, the studies reviewed above indicate that professional socialisation occurs as a process during the education and training of nurses. The process is a powerful one wherein nurses, as with other professionals, learn the attitudes, values and behaviours required to assume their professional roles (Howkins & Ewans 1999). However, role is a basic unit of socialisation (Goffman ([1961] 2013) and one which is central to understanding *how* nurses experience the transition to professional status. Role theory is therefore of particular relevance to the present study and is discussed next.

## **2.4 Role theory**

Role and role concepts have arisen from social-anthropological foundations and have led to the development of a framework sometimes called role theory (Goffman [1961] 2013). Role theory is concerned with status as a position in social structure, with socially defined attributes and normative expectations of behaviours as roles are enacted (Clancy *et al.* 2006). It includes notions of role allocation, how individuals are assigned roles and the dynamics of that process.

Concepts of role theory have been outlined by Handy (1993) and provide a useful language for understanding processes involving individuals and the organisations within which they work. Role set has been defined by Handy (1993) as the people with whom the focal person, or the individual with whom one is concerned, has more than trivial interactions. For example, in a family situation the focal person may have a role set comprising of his parents, his wife, her parents, neighbours, his friends, her friends, joint friends, child A, child B, children's school, etc. Role definition occurs as a result of role expectations and role ambiguity results from unclear role expectations. Role overload occurs when we feel the numbers of roles we hold are too many. This concept is different to that of work overload, which is defined as occurring when there is too much to do in one role. Handy suggests that we hold a number of roles and most people can handle some measure of role conflict, which is defined as conflicting or overlapping roles, for example, paid worker and mother. Conversely, role underload can occur when in the opinion of the individual their given job is well below their capabilities. Stress, according to Handy (1993), is inherent in organisations and can be healthy (role pressure) or unhealthy (role strain), and some individuals have a higher tolerance for stress than others.

The functionalist and interactionist perspectives provide ways to theorise roles; however, individually they may not fully explain the processes which occur. Goffman (1959, [1961] 2013, 1967) developed approaches to roles which are hard to align to either perspective (Scheff 2005, Smith 2011). For Goffman, symbolic interactionism is a category awaiting content and does not offer the substance needed for sociological analysis. Moreover, functionalism offers a limited perspective. Instead, to unpick how the process of taking up a role was worked out between people, Goffman adopted the use of metaphors. He used them as an analytic device to tease out overlooked or hidden features of interactional conduct (Smith 2011). Three of the metaphors he used were: game (Goffman 1961), ritual (Goffman 1967) and drama (Goffman 1959). Game is concerned with the potential for individuals to control and manage information about themselves, ritual with forms of regard and respect manifested interactionally, and drama with “life as theatre”.

#### **2.4.1 Goffman’s dramaturgy**

Goffman (1959) proposed a dramaturgical interpretation of roles to theorise the presentation of “self” in everyday life. Using concepts from the theatre such as “performance”, “actors” and “audience,” Goffman demonstrated the dramaturgical problems involved in presenting activity before others and in so doing offers an interpretation of events.

In his book *The Presentation of Self in Everyday Life* (1959), Goffman produced a type of “handbook” (Fine & Manning 2003) which contains six dramaturgical themes: performances; teams; regions and region behaviour; discrepant roles; communication out of character; the art of impression management. Interaction is defined as the reciprocal influence of individuals upon one another’s actions when in one another’s immediate presence. An encounter or an interaction is that which occurs during one occasion when individuals are in one another’s continuous presence. A “performance” is all the activity of a given participant on a given occasion which influences the other participants in any way. Goffman takes the participant and their performance as the basic reference point and those who contribute the other performances as the “audience”. When a pre-established pattern of action is played out during a performance, and which can be played out on other occasions, this is a “part” or a “routine”. As Goffman states, these situational terms can be easily related to conventional structural ones. Learning the student nurse “part” is an example. Moreover, when a performer plays out the same part to the same audience on different occasion a social relationship is likely to arise, as with student nurses and their mentors in clinical

practice. Social role is concerned with acting out rights and duties attached to a given status. It involves one or more parts and each of these may be presented by the performer on a series of occasions to the same kinds of audience or to an audience of the same persons.

Goffman's (1959) dramaturgical analysis extends beyond individuals and the difficulties involved in putting on a convincing performance to teams and team performances. It also extends beyond social space to the organisation of physical space, and he describes "front" and "back" stages or regions. A public performance is given on a "front" stage by a "team" of performers, but in the back stage area the performance may be knowingly contradicted. Here the performer can relax, drop their front and step out of character (Goffman 1959).

In a later work Goffman ([1961] 2013) used the term "role set" and further explained that for each role we act out there are a number of associated sub-roles related to the role set. For example, doctor/nurse is a subset of the doctor role and is doctor/patient is another. For Goffman the concept of role, though commonly used, wavers when looked at closely (Goffman [1961] 2013). However, he suggests that it is not the individual but the individual "enacting his bundle of obligatory activity" (Goffman, [1961] 2013, p. 86) which is the elementary unit of role analysis. In performing a role, Goffman states, it is important to note that the individual must make their impressions fit with the role-appropriate personal qualities imputed to them. So, for example, a judge is supposed to be deliberate and sober and a bookkeeper accurate and neat in their work, and a nurse competent and kind. For Goffman we are the roles we perform:

Personal qualities effectively imputed and effectively claimed combine with a positions title, where there is one, to provide a basis of self image. A self then virtually waits the individual entering the position (Goffman, [1961] 2013, p. 87).

This statement effectively bears out the assertion by Olesen and Whittaker (1970) that socialisation, of which role is a constituent part, spans the fields of both sociology and psychology and might be seen as a functionalist approach.

Goffman has been criticised on a range of fronts, most notably on the "two selves thesis"; one self being a public performer carefully managing impressions and the other a cynical manipulator hidden behind the public performance. The two selves thesis explains the common belief that the dramaturgical perspective is a cynical view of social life which implies that all relationships are

inauthentic and self serving (Fine & Manning 2003). In addition, Goffman has been criticised for neglecting history and focusing on face-to-face interactions to the exclusion of wider social factors. He has also been accused of providing a partial account, privileging the middle classes (Smith 2011). However, he did seek analyses that extended beyond particular social classes to encompass universal elements. In addition, his work on rituals provides a moral dimension to his work where he articulated forms of regard and respect manifested internationally (Smith 2011). Moreover, Goffman's dramaturgy does not impute motivations for performances, nor does he express a pessimistic view of human nature (Tanner & Timmons 2000). Instead his work is a way of analysing performances through interactions.

A dramaturgical metaphorical analysis cannot be held to account for history (Smith 2011) and account for transitions and change over time. It can be seen to imply a society of scenes with no plots (Sennett 1977). Dramaturgy, with its emphasis on roles and performances, can help to explain the interactions and problems of presentation which occur when an individual changes work roles, but cannot fully explain the overarching process of transition. A work career can be conceptualised as a series of transitions from one role to another within an organisational or occupational system (Trice & Morand 1989). Therefore, transition theories provide a framework for understanding the processes that occur over time when individuals change their work role. Together with a dramaturgical approach, they can begin to answer the question of just how transitions between work roles are accomplished. They can provide an explanatory framework for developing understanding of the overall pattern of transition that students who have previously worked as HCAs might experience, but also, within the overall pattern, their experiences of role change as they take up the mantle of student nurse.

## **2.5 Transition theories**

Transition theories and models of transitions can be broadly conceptualised in three major categories (Table 2.1). First are the grand theories which are applicable to a wide range of social contexts and fields of enquiry presented alongside generic models of transitions (Cresswell 1994). Second are the middle range theories which fall between the minor working hypotheses of everyday life and all-inclusive grand theories. Third are substantive theories restricted to particular settings and groups (Cresswell 1994). Common to all theories of transition is the notion of change



involving movement between two points and an inner reorientation as a person adapts to change (Kralik *et al.* 2006).

**Table 2.1 Theories of transition: grand, middle range and substantive**

Theory type	Focus	Concepts	Author
<b>Grand theory</b>			
	Rites of passage	3 stages: separation, transition, incorporation	van Gennep ([1909] 1960)
	Status passage	6 key principles: reversibility, temporality, shape, desirability, circumstantiality and multiplicity	Glaser & Strauss (1971)
	Force fields	3 stages: unfreezing, changing, refreezing	Lewin (1947)
<b>Middle range</b>			
	Organisational change	3 stages: ending, neutral zone, beginning	Bridges (2009)
	Work roles	5 stages: preparation, encounter, adjustment, stabilisation, preparation	Nicholson & West (1989)
	Nursing knowledge	4 categories: developmental, health–illness, organisational, situational	Meleis (2010)
<b>Substantive theory</b>			
	Families' transitions	19 elements: e.g. anticipatory socialisation, role conflict, incompatibility, compartmentalisation, strain, clarity	Burr (1972)
	Newly qualified professionals (nurses)	Stages of doubt, loss, disorientation and confusion framed in relationships, knowledge, roles and responsibilities	Boychuck Duchscher (2009)
	Experienced professionals' role change (newly qualified nurse practitioners)	Laying the foundation; launching; meeting the challenge; broadening the perspective	Brown & Olshansky (1997)
	Student role (HCA turned student nurse)	Process model: role identity/confusion, formal/informal exposure, reality shock, culture shock, professional issues, clinical issues, comfort zone	Brennan & McSherry (2007)

### 2.5.1 Grand theories of transition

A highly influential anthropological model known as rites of passage was developed by van Gennep ([1909] 1960), who proposed that individuals move between fixed positions or events such as birth, childhood, marriage and death. Van Gennep suggested a common pattern was discernible to show how major transitions are managed ceremonially across three stages: separation, transition (or limen) and integration. He called this schema “*rites de passage*”, or the pattern of rites of transition (Draper 2003). Three distinct rites make up the passage ceremony. Rites of separation act to detach people, often physically as well as symbolically, from their former roles and move them to the transitional or in-between phase. During this stage former statuses and roles are stripped away and the rite puts people in an ambiguous state or “in no man’s land” (Draper 2003). Finally, rites of integration consist of collective actions that function to incorporate newcomers into their new roles. This clearly staged theory of transition with its structural/functionalist underpinnings (Draper 2003) and linearity (Kralik 2006) has influenced many of the theories and models of transition that have since been proposed, including Holland (1999) discussed above. However, the theory can be criticised as descriptive and functional in nature (Gluckman 1962). In addition, its heavy focus on the sacred and ceremonial rituals found in semi-civilised societies (Watts 2013) can call into question its relevance in today’s post-modern society. According to Gluckman (1962), the theory fails to develop implications, but it has been extended (Turner 1987) to explore more fully the notion of liminality or transition. In addition, it can be usefully applied to the changes that nurses experience in their education and working lives (Watts 2013).

From a sociological perspective, Glaser and Strauss (1971) also sought to generate a theory of status passages. Through the constant comparative approach outlined in *The Discovery of Grounded Theory* (Glaser & Strauss 1967) they developed a formal theory. They did not assume that passages are regularised, scheduled and prescribed in the way van Gennep describes, though they did acknowledge that these properties might be present in particular circumstances. They sought additional properties that characterise a passage, arguing that anthropologists had focussed attention on too limited a range of “relatable phenomena” (Glaser & Strauss 1967, p. 6). Rather than present the formal theory, Glaser and Strauss organised their work through six key principles: reversibility, temporality, shape, desirability, circumstantiality and multiplicity.

In the first of Glaser and Strauss's six principles, reversibility includes considerations such as direction, repeatability, arrestability, inevitability and preventability. The principle of temporality concerns matters such as schedule, regularity, prescribed steps, pace and speed. Shape is concerned with periods and plateaus along with the crucial issue of "control" over the passage. Desirability refers to passages, and the desirability or undesirability of the passage and its voluntary or involuntary character. Circumstantiality relates to persons making the passage alone or in aggregate or collectively. Lastly multiplicity, involving multiple status passages, suggests that people are simultaneously engaged in many such passages (Glaser & Strauss 1967, p. 12). These principles emphasise different aspects of career development as individuals move between roles and are subject to a range of influences and expectations (George 1993). This nuanced view of the transitional process nonetheless holds features in common with van Gennep's ([1909] 1960) theory.

Glaser and Strauss (1971) view the transitional state, as does van Gennep, as a status passage. Their work was influenced by van Gennep (Barton 2007) and, according to Barton (2007), other models of social transition (Lewin 1951, Becker *et al.* 1961, Woods 1999, Glaze 2002; Brown & Draye, 2003) also hold much in common with van Gennep's seminal work. However, on closer inspection Brown and Draye (2003) focus their study on autonomy and find this a central theme in establishing advanced nursing practice roles, and Glaze (2002) uses Meleis *et al.*'s (2000) emerging middle range theory to explain transitions. But nonetheless van Gennep's theory is pervasive and does influence the way in which models of social transition, such as those identified by Barton (2007), are read and perceived.

Role transitions were conceptualised by Lewin (1947) as a form of separation from an old role and of transitions and incorporation into a new role (Trice & Morand 1989). Lewin's work combines psychology with sociology and cultural anthropology and proposed "force fields" relating to group standards, decisions and procedures, all of which impact on individuals. The work on force fields captures elements common to all change processes and his three stages of unfreezing, changing and refreezing conceptually parallel the separation, transition and incorporation phases of van Gennep's ([1909] 1960) rites of transition. However, and perhaps unsurprisingly, Lewin's stages have been used most consistently to model the psychological processes involved in attempts to influence individuals' beliefs, attitudes and values (Trice &

Morand 1989). Lewin himself stated (1947, p. 13) that the mathematical representation of the social problems he presented should not be misunderstood as trying to minimise the importance of cognitive processes and psychology on group life.

Grand theories of transition such as those above are highly influential, providing a bedrock of understanding from which other theorists and researchers can draw. This is demonstrated in the following two sections on middle range and substantive theories. First middle range theories are discussed.

### **2.5.2 Middle range theories of transition**

Writing from the perspective of organisational change, and directing his work to managers and employers, Bridges (2009) also proposes a three-stage model of transition. In this significant work (Meleis 2010), Bridges (2009) argues that transition is the psychological process that people go through to come to terms with a new situation. The psychological/sociological approach to change and transition echoes that of Lewin (1947). Bridges (2009) distinguishes change from transition, seeing change as situational and external to the individual and transition as an internal process. He identifies transition as comprising an ending, a neutral zone, and followed by a new beginning, echoing both Lewin's (1947) and van Gannep's ([1909] 1960) three-stage theories. Moreover, Bridges describes the "neutral zone" as "no-man's-land" (Bridges 2009, p. 8), clearly in parallel with the state of limen described by van Gannep ([1909] 1960). However, the stages Bridges identifies are not viewed as separate with clear boundaries, but instead curving, slanting strata that can overlap. Individuals in transition are viewed as being in more than one phase at any one time and the movement through transition is marked by change in the dominance of one phase as it gives way to the next (Bridges 2009).

In further work Nicholson and West (1989), writing as social scientists interested in careers, suggest that the study of transitions can achieve integration of many disparate orientations found in the study of careers. In earlier work Nicholson (1987) developed a conceptual framework for analysing modes of adjustment to transitions, experienced over work histories and lifetime careers. The framework links the person and their situation with individual and organisational outcomes, although, as Nicholson himself notes, phase models linked to aspects of transition such as the one he put forward (replication, absorption, determination and exploration) are open to the

charge of over-simplification and over-generalisation. Later (1989), he proposed a process model of the transition cycle comprising five stages: preparation, encounter, adjustment, stabilisation and preparation. Preparation involves the process of expectation and anticipation before change take place. Encounter is concerned with the affect and sense making during the first few days or weeks of job tenure. Adjustment refers to the subsequent personal and role development to reduce person–job misfit. Stabilisation is seen as the settled connection between person and role, and finally preparation entails the renewal of the cycle (Nicholson & West, 1989).

Nicholson's model encompasses three main assumptions which distinguish this model in key respects from van Gennep's structural/functionalist (Draper, 2003) and linear theory of role transition. First is the notion of recursion, meaning that the last stage of one cycle is the first of the next. If change is rapid, cycles may short-circuit one another. For example, adjustment may be interrupted by the preparation and encounter stages of a new cycle. Student nurses' rotation through clinical placements illustrates the point. Students may still be adjusting to their placement when they may find themselves encountering a new placement, or within a different section of an existing placement, such as the anaesthetic room or the recovery room in an "Operating Theatres" placement. Second, interdependence, meaning the content of experience at one stage, will strongly influence the content of experience at subsequent stages. For example, inappropriate preparation heightens the challenge of encounter and adjustment. For student nurses, prior placements may not provide good preparation for subsequent placements, such as wards for operating theatres. Third is distinctiveness, meaning that experiences have distinct qualities at each stage because they invoke different psychological and social systems (Nicholson & West, 1989). For example, students may find an operating theatres placement a difficult experience in a strange environment.

In common with anthropological models of transition, Nicholson's model assumes transitions are patterned in predictable ways (George 1993). Additionally, Nicholson's model may not account sufficiently for heterogeneity and social context. For these reasons, as with other models of transition, it may be "doomed to failure" (George 1993, p. 368) because it cannot be easily applied to a wide range of disciplines. However, the occupational context provides the most successful arena from which to integrate macro and micro findings (Nicholson & West 1989, George 1993), uniting the individual, their role and the organisation in which they work. Nicholson's model may

be open to development as it is concerned with job change and how the newcomer adjusts the role to “preserve and enact valued aspects of identity” (Nicholson & West 1989, p. 186). However, some newcomers such as learners and apprentices are not in a position to mould roles and instead are in pursuit of a new work role identity. A revised model could account for the macro and micro aspects involved in being a learner where adjustment to rotating work placements take place.

An approach to transitions located within the nursing literature and developed over a period of three decades is taken by Meleis (2010), who traces the evolution of a theory of transition from concept to nursing theory. Drawing on nursing practice, Meleis sought to develop understanding of transitions to advance nursing knowledge. An outline of an emerging middle range theory was described by Meleis *et al.* (2000) and supplementary research and theoretical explorations led to further confirmation of the theory. This theory outlines four major categories of transitions that nurses encounter: developmental, health–illness, organisational and situational transitions (Meleis 2010). However, Meleis *et al.* (2000) stress that while discrete categories can be identified, transitions are often multiple and complex, and do not occur in isolation.

Developmental transitions include a wide variety of events that trigger a process of transition. For example, the process of becoming a parent, motherhood and fatherhood, the menopause, ageing, homelessness and divorce are all examples of developmental transitions that nurses encounter. Health–illness transitions are related to medical conditions such as myocardial infarction and its effect on individuals and their families. Health–illness transitions are influenced by cultural diversity, illness diversity, and the stage in a person’s lifespan. Organisational transitions are concerned with environments that pertain to nurses. Organisational transitions may be driven by the wider social, political or economic environment as well as changes in the structure and dynamics of organisations. Changes in leadership, policies, procedures and practices have been identified with the process of organisational transition (Meleis 2010).

Situational transitions can be related to geographical changes and, for example, to discharge from hospitals, as well as relocation to rehabilitation or to care homes. Immigration and migration, as well as work, are also examples of situational transitions relevant to nurses. Nurse education acts as a trigger for situational transition related to work. Nurse researchers have found this to be a

fertile area for investigation as nurses move from one educational level to the next (Meleis 2010). However, the work of Meleis is largely concerned with the role of the nurse in facilitating the transition processes that patients and clients experience (Chick & Meleis 1986, Schumacher & Meleis 1994, Meleis *et al.* 2000, Meleis 2010). For Meleis the triad that forms the basic structure of nursing knowledge comprises human beings, the environment and health (Chick & Meleis 1986). A central concern is with nursing therapeutics and how these may promote, prevent and incentivise transitions. Meleis emphasises the event, meaning and consequences of transitions and the nurse's role as a facilitator of transitions rather than nurses themselves in transition. However, the theory does include organisational and situational transitions as types which nurses experience, although nursing therapeutics remains a central element in this emerging middle range theory (Meleis 2010).

Meleis' theory, like those of Bridges (1972) and Nicolson and West (1989), provide a somewhat greater specificity to particular groups and settings than grand theories such as that espoused by van Gennep ([1909] 1960). More specific still are substantive theories of transition. These more restricted theories are discussed next, although, as with the middle range, the influence of grand theory can be detected.

### **2.5.3 Substantive theories of transition**

From a sociological perspective, Burr (1972), like Glaser and Strauss (1967), set out to build a theoretical model of propositions involved in transitions. Burr's intention was to develop a model that can be used as a basis for deductively explaining why variation occurs in the ease of transitions. Using the literature on families, Burr (1972) identified and reworked 19 propositions that were general, yet precise. He organised them in a flow chart indicating the variables and their relationships. Elements in this theory include anticipatory socialisation, role conflict, role incompatibility, role compartmentalisation, role strain and role clarity, among many others. Although a fairly complex model derived from the family literature, this theory may be sufficiently generic to test the ideas in other fields of study. And although the model lacks the parsimony and wide applicability of van Gennep's ([1909] 1960) renowned grand theory, or the synthesis sufficient to claim formal or grand theory status such as presented by Glaser and Strauss (1971), Burr's focus on ease of transitions may appeal to those studying occupations such as nursing and the impact of role transitions.

A theory of “transition shock” has been proposed by Boychuck Duchscher (2009). This theory is derived from a research programme spanning ten years and four qualitative studies. Three of these studies were conducted in Canada and one in Australia and all relate to newly qualified nurses’ experiences of becoming an RN. The theory builds on elements of transitions theory, reality shock and cultural shock as well as theory related to professional role adaptation, growth and development. It outlines stages of doubt, loss, disorientation and confusion and is framed in relationships, knowledge, roles and responsibilities. Although specifically related to newly qualified nurses, this theory indicates the upheavals experienced as changes occur: physical, intellectual, emotional; developmental and socio-cultural.

A further theory of transition, and this relating to newly qualified nurse practitioners, is proposed by Brown and Olshansky (1997), again from a North American study, this time from the USA. This study describes the experiences of 35 newly qualified nurses via focus group discussions at 1, 6, and 12 months following graduation. It presents a theory of transition to primary care practice. Grounded theory method guided data collection and analysis to establish a model encompassing four major categories: laying the foundation; launching; meeting the challenge; broadening the perspective. The model once again highlights the distress involved when change and transition occur but also points to some of the accomplishments which take place during the process.

Also within the nursing literature, a study by Brennan and McSherry (2007) describes a framework which is built on existing nursing literature and influenced by anthropological and sociological theory. It is the only study to date in the nursing literature which focuses on the transitions of pre-registration student nurses with prior HCA experience and which proposes a theoretical model of their transition and socialisation processes. The authors used a cross-sectional design and held four focus groups with students studying the Adult Branch of nursing. Interviews took place with students at four different points in their pre-registration nursing programme, each group consisting of three or four students and together totalling 14 students. Thematic content analysis was used to interrogate the data and member checking employed.

The concepts in Brennan and McSherry’s prior framework taken from the existing literature are: role identity and role confusion, formal and informal exposure and reality shock. Role identity and



role confusion are concerned with the potential for confusion that exists for the HCA-turned-student in identifying their new role. Reality shock, taken from the work of Kramer (1974), is described as the unpreparedness that nurses feel in situations which they believed they were prepared for. Formal and informal exposure is concerned with the exposure that the former HCA has to the qualified nurse's role. This is important because qualified nurses are seen by students as role models who hold significant influence over the socialisation process (Brennan & McSherry 2007). The authors identified and added to the existing framework the main themes of culture shock and clinical issues. Culture shock refers to a process experienced by HCAs who mistakenly thought skills previously developed as an HCA would carry them through the initial stages of their training. Clinical issues concern participants' clinical placements and being used as an HCA at the expense of their learning as a student. Brennan and McSherry also identified professional issues, including the professional role and accountability, and incorporated this into the "emerging framework" (Brennan & McSherry 2007, p. 212). Also added was a new concept, "the comfort zone", which refers to the intentional reversal into the HCA role by the participants in the study. The authors suggest it is a model which can be further developed.

The model proposed by Brennan and McSherry, as with many anthropological and careers theories of transition, assumes regularised, scheduled and prescribed modes of transition (Glaser & Strauss 1967). It may not therefore be applicable to a wide range of disciplines and contexts, but does not purport to be such. Its usefulness lies in its career specificity with the potential to integrate micro and macro findings: the individual and their social context.

## **2.6 Studies of the transition from HCA to student nurse**

To find out more about the particular transitions experienced by student nurses with prior HCA experience, a basic search of the databases CINAHL, BNI and Medline was carried out. The key words "Health Care Assistant", "student nurse" and "transitions" were used and nine studies were identified. Three studies were identified concerned solely with the transitions of students with prior HCA experience (Roberts 2006, Brennan & McSherry, 2007, Mayne 2007). A study by Wood (2006) also focused solely on students with prior HCA experience but, as noted above, more narrowly on the process of professional socialisation. Two studies were identified which discussed pre-registration students' transitions *per se* (Holland 1999, Andrew *et al.* 2009). Finally, evaluations of programmes such as secondment to pre-registration nursing programmes and

audit of selection processes were identified (Gould *et al.* 2004, 2006, Swallow *et al.* 2007, Southgate & Felstead 2010).

Of the three studies which were found to focus exclusively on the experiences of nursing students with prior HCA experience (Roberts, 2006, Brennan & McSherry, 2007, Mayne, 2007), only two focus on both students and the process of transition (Brennan & McSherry 2007, Mayne 2007). The study by Roberts (2006) was focused on the academic experiences of seconded students with prior HCA experience. Roberts concluded that although there are some disadvantages, these students benefited from being taught in segregated groups. However, Roberts states that the findings may not be generalised due to the small sample size. Twenty-seven out of 29 students responded to a questionnaire at the end of their three-year programme as part of course evaluation. The questionnaire was administered to one cohort of students and had not been assessed for reliability and validity.

The study by Mayne (2007) discusses seven students in Scotland with Clinical Support Worker (CSW) experience. However, this study did not examine former HCAs undertaking a pre-registration programme. Instead it analysed the transitional experiences of CSWs undertaking a one-year HNC course in health care, designed to prepare students for entry to pre-registration nursing programmes. A phenomenological and case study approach was taken. Seven out of 8 invited students responded to a questionnaire and then took part in a focus group discussion. In addition, “quantitative” data were obtained from placement reports and academic assessments. Mayne (2007) reported that students were both daunted and excited, and that role confusion characterised their experiences. The discussion of the processes of socialisation and transition are discussed and conflated in this study, as is evident in the discussion of van Gennep’s theory as a model of socialisation. Mayne (2007) concluded that this group requires special recognition, and special support, in order to improve the process of transition and recruitment and retention rates.

In the only study that focuses on the transition and socialisation processes of pre-registration students with prior HCA experience, Brennan & McSherry (2007) used existing literature to develop a basic explanatory framework, then added the findings from their study to develop it further. This study and the theoretical model presented was discussed above (Section 2.5.3).

A second subset of literature was identified from the basic search which focuses on student nurses' transitions per se (Holland 1999, Andrew *et al.* 2009) but not solely on HCAs. Both studies shed light on HCA-turned-student nurse transitions. Holland (1999) linked anthropology and nursing and adopted an ethnographic methodology to explore the culture of nursing. Participant observation and interviews were chosen as methods for data collection within the field of nursing practice alongside non-participant observation in the nursing college and distribution of questionnaires. This was a cross-sectional study with longitudinal elements. Four groups of students undertaking the Adult Nursing Branch were selected as informants but numbers of hours undertaken in observation and numbers taking part in interviews and the survey are not recorded. Holland (1999) concluded that an important aspect of nursing culture is the established arrangement for socialisation of new members. Part of this process involved learning the cultural rules as students undergo a process of transition through different clinical settings. Parallel subdivisions to the rites of passage as described by van Gennep ([1909] 1960) were found.

The study by Holland (1999) did not distinguish between the experiences of students with health care experience and those without, but it makes an important contribution to understanding the transitions that pre-registration students in general experience. It also raises questions and concerns about the dual role of HCA and student that some students undertook while undergoing their education and training. Holland (1999) outlined the confusion students felt when working as an assistant nurse and the skills they were able to perform. At the time the study was conducted students expressed frustration at not being allowed to perform tasks such as dressings and blood pressure readings when acting as an auxiliary nurse. This situation is now often reversed because, as discussed in Chapter 1, today many HCAs are trained for tasks which student nurses are not permitted to carry out.

The second study concerning student nurses per se and their transitions was conducted by Andrew *et al.* (2009), in Scotland a decade later than the study by Holland. In contrast to Holland's study it took a largely quantitative approach. Students were surveyed to develop an understanding of the academic and clinical skills which support pre-registration nursing students during year one. Five hundred and fifty-five questionnaires were sent to students on completion of their first clinical experience and 418 students (75%) responded. The response rate was lower

than the 80% target, potentially impacting on the usefulness and transferability of findings generated through the SPSS statistics software package. To broaden the investigation some key findings were presented at a one-day conference to first-year stakeholders. The findings from this study highlight the importance of the academic and practice transitions students experience in year one of undergraduate study and the impact they have on the successful completion of programmes of preparation for registration. The group discussion following the presentation of findings at the conference indicated that effective support for year one students was required as a clinical and academic priority. However, the study by Andrew *et al.* (2009) did not distinguish between the experiences of students with prior HCA experience and those with none.

The final subset of literature found in this initial search can be broadly conceptualised as programme evaluations (Gould *et al.* 2004, 2006, Swallow *et al.* 2007, Southgate & Felstead, 2010). These studies evaluate or audit programmes and performances but do not seek to add to the body of knowledge on transition experiences, nor do they add to methodological debates. Rather, they serve to inform interested parties on the efficacy of the programmes reviewed. The outcomes of these studies are mostly restricted to recommendations that enhance delivery of those programmes.

An evaluation of a scheme in London through which HCAs were seconded by NHS employers to a pre-registration programme was conducted by Gould *et al.* (2004). This qualitative, exploratory study sought information on how the scheme was perceived by those taking part in it. Interviews took place with two consecutive intakes of secondees at 3, 12 and 36 months into the programme. Interviews were also conducted with a range of stakeholders and practitioners who facilitated student learning. The data from this project suggested that secondees were overall satisfied with their experiences throughout the programme, although they were challenged by theoretical components, especially science. They performed well in clinical elements, although some students reported that they avoided exploitation and being treated as a pair of hands by developing tactics such as not discussing their prior experience with mentors and other placement staff.

Following on from the study in 2004, Gould *et al.* (2006) produced another evaluation. They examined the role transition of newly qualified nurses previously employed as seconded students.

This study was described as an “in depth study” (Gould *et al.* 2006, p. 561), but the small sample of four participants is a key shortcoming (Culley 2006). However, unexpected findings were recorded, including the limited benefits of previous HCA experience. In addition, it was found that former HCAs harboured great fear of failing the programme because they are expected to return to the clinical area that sponsors them when they finish their studies. They feared the ignominy resulting from the public nature of failure on their return to the clinical setting that sponsored them. Gould *et al.* (2006) also highlighted that former HCAs experienced other anxieties, which related to academic aspects of their programme and to new responsibilities. The authors finally concluded that HCA secondments may not offer a ready solution to increasing the qualified workforce.

Swallow *et al.* (2007) evaluated a new programme in the North East of England aimed exclusively at HCAs, enabling them to step on to year two of a Dip HE programme in England. The aim was to investigate the development and implementation of the programme and to recommend practical actions for its improvement. Twenty HCAs and 20 mentors plus three Trust facilitators and three university tutors took part in focus group discussions. Subsequently, 20 questionnaires were distributed to elicit individual views of mentors on experiences of the programme and 12 responded. The main recommendations of the study related to infrastructure development in collaborating NHS Trusts. The need for clarification of the student role emerged as an issue and practical recommendations such as wearing a different uniform were suggested to clarify roles. This study, like that of Gould *et al.* (2004), recognised the importance of prior HCA experience on studentship, though neither study explores students’ experiences in depth or detail.

Last in this group of studies, an audit of seconded students was undertaken by Southgate and Felstead (2010). This study aimed to examine whether a relationship could be established between entry qualifications and secondment interview scores and the academic success of secondees in two pre-registration programmes. Findings resulted in criteria being upgraded for both interview scores and entry to pre-registration programmes.

The limited literature in this section indicates that the transition experiences of student nurses with HCA work experience can be problematic. As the studies by Holland (1999) and Andrew (2009) indicate, the general transitions of student nurses to RN can be problematic. However, studies

centred on students with prior HCA experience suggest that in addition, former HCAs' transitions can be influenced adversely by their prior role. Role confusion (Holland 1999, Mayne 2007), dissonance (Gould *et al.* 2004) and retreat to a comfort zone (Brennan & McSherry 2007) provide examples of the difficulties former HCAs can experience. Moreover, programme evaluations and audits suggest that difficulties also exist for the organisations which sponsor and give clinical experiences to former HCAs and special support may be needed (Swallow *et al.* 2007, Southgate & Felstead, 2010).

## **2.7 Conclusion**

In this chapter theoretical perspectives which can illuminate the transition from experienced worker to professional were reviewed. Theories of transition were discussed and commonalities included they involve movement from one state to another, are prompted by change and characterised by stages of change which take place over time (van Gennep [1909] 1960, Glaser & Strauss 1971, Burr 1972, Bridges 1972, Nicholson & West 1989, Kralik *et al.* 2006, Meleis 2010). It was also noted that theories of work role transitions are useful as they hold the ability to unite the individual, their role and the organisational context within which individuals work. The empirical studies discussed throughout this chapter took cross-sectional and longitudinal approaches to data collection to track change over time. These are characteristics relevant to the present study and are recommended for studies of transitions (Kralik *et al.* 2006).

Further, the literature in this chapter indicates that theories of transition have been discussed alongside socialisation processes (Holland 1999, Wood 2006, Brennan & McSherry 2007, Mayne 2007, Andrew 2009). Moreover, role theory, an aspect of socialisation, can contribute to the study of transitions because role entry and exit are transitions by definition, and learning how to function in a new role is a constituent part of the process of transition (George 1993). This chapter suggests that dramaturgical approaches, together with theories of transition, can provide a complementary and comprehensive picture of work role change relevant to this study. Experiences of transitions and factors which facilitate and constrain them can be examined through the lens of the performances which are enacted when new roles are learned. In addition, the literature suggests that to develop understanding of the transition from experienced worker to professional, an existing model of transition could be enhanced (Nicholson 1989, Brennan & McSherry 2007).

The combination of transitions and role is explored further in Chapter 3 where a systematic literature search for studies of nurses' experiences of work role transitions is reported. Chapter 3, alongside this chapter, provides the foundation for meeting the aims and objectives of this study and for the empirical work to follow.

## **Chapter 3 Nurses' perceptions and experiences of work role transitions: a review of the literature**

### **3.1 Introduction**

The literature in Chapter 2 reviewed a broad range of theories and empirical studies which shed light on nurses' work role transitions. This chapter provides greater focus. The aim of this mixed methods systematic review is to understand nurses' work role transitions and this aim was more narrowly focused to encompass two review questions (Thomas *et al.* 2003):

- 1 What are nurses' perceptions and experiences of work role transitions?
- 2 What are the facilitators of and constraints to work role transitions that nurses experience?

Section 3.2 of this chapter outlines the design of the review, then Section 3.3 presents the search results. Section 3.4 provides a discussion of the results and Section 3.5 the limitations of this review. Section 3.6 concludes this review.

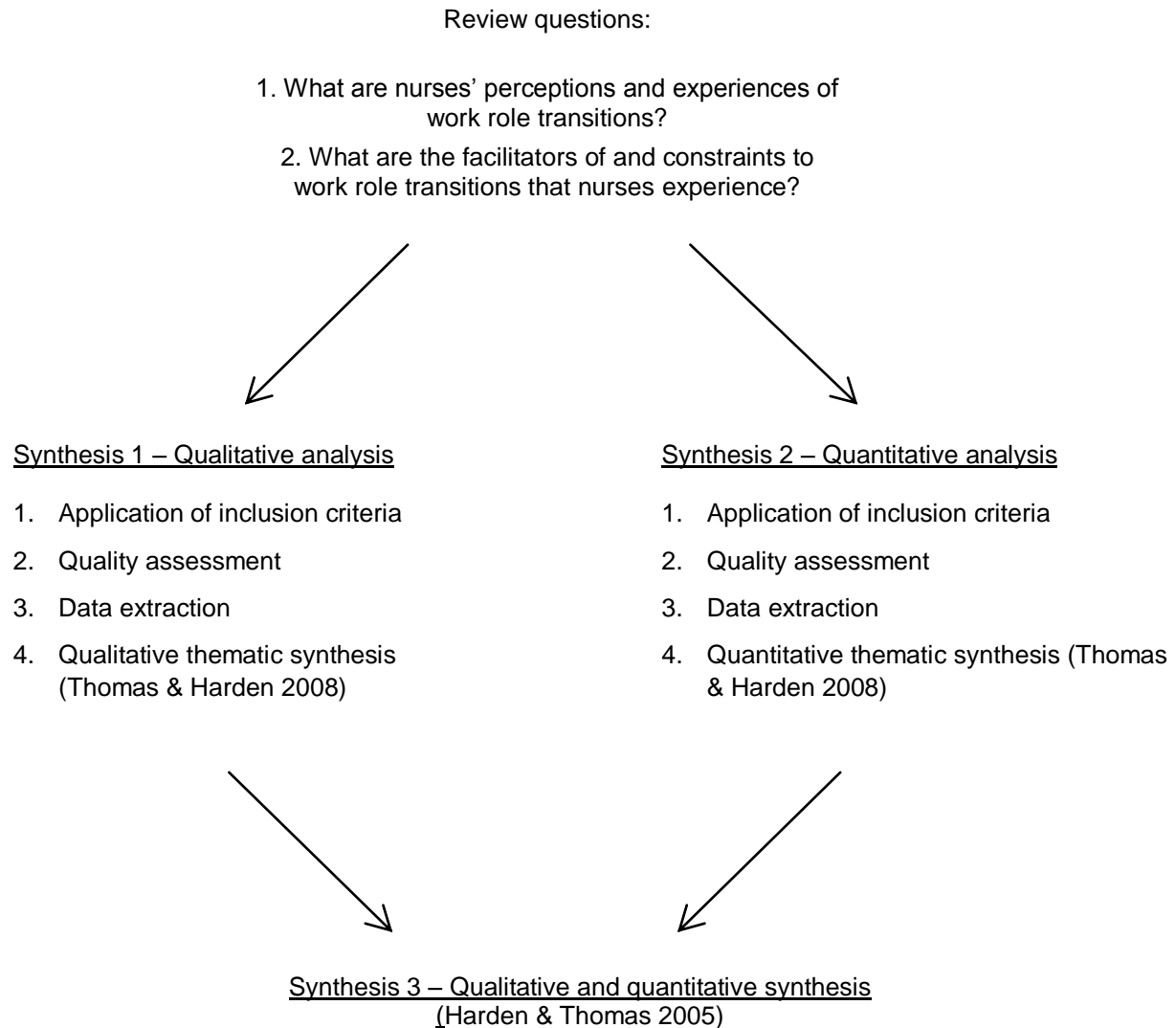
### **3.2 Scope of the review: design and methods**

#### **3.2.1 Design**

This review follows standard search procedures (EPPI-Centre, 2010). It begins with the review question, searches for and samples the literature, and applies inclusion/exclusion criteria. The Harden and Thomas (2005) methodological approach for combining diverse study types and the Thomas and Harden (2008) approach for thematic synthesis were adopted.

Both "quantitative" and "qualitative" papers were included to fully address the review questions. The terms quantitative and qualitative relate to numerical data analysis (e.g. descriptive/inferential statistics) and textual data analysis (e.g. thematic analysis) respectively and the papers included in this review were classified accordingly (Harden & Thomas 2005). Analysis and synthesis of the qualitative and quantitative papers took place separately and a third synthesis combined the outputs (Figure 3.1).





**Figure 3.1 Mixed methods study design**

The inclusion criteria (Table 3.1) and exclusion criteria (Table 3.2) were the same for both qualitative and quantitative papers and the quality of papers in each stream was appraised separately using adapted published templates (Appendices 3.1 and 3.2). The data were abstracted from the qualitative papers' textual data and from the quantitative studies from the narrative of their descriptive and inferential findings. Findings from both streams were thematically synthesised (Thomas & Harden 2008). The themes taken from the qualitative synthesis provided the mechanism for combining the quantitative narrative of the descriptive and inferential statistics with the qualitative findings (Harden & Thomas 2005). Below is a summary of the studies including pathways through work role transitions and aspects of transition codes (see Appendix 3.5). The study characteristics, the codes and the themes generated from the codes and the

pathways identified through the transition process created a matrix which facilitated constant comparative analysis. Movement back and forth between the codes and descriptive themes found in the thematic analysis of textual data and the thematic narrative descriptions of statistical analyses facilitated integration of each synthesis and generated analytic themes common to both. A narrative empirical synthesis of the literature is the resulting outcome (EPPI-Centre 2010).

### **3.2.2 Search strategy**

The search was completed in October 2015 by accessing the electronic databases: CINHAL; British Educational Index; Australian Educational Index; ERIC; PsycINFO; PUBMED. Papers were identified using the key terms: transition\*, role and nurs\*. The Boolean operator AND was selected (transition\* AND role AND nurs\*) to retrieve a full yet focused range of papers. Hand searching of reference lists for papers which were not identified in the electronic databases was performed and citation searches supplemented this approach.

### **3.2.3 Inclusion criteria**

Primary empirical research in peer-reviewed English language journals published between January 1990 and October 2015 were included in this review. The start date reflects the integration of nurse education into Higher Education in the UK. This included the change from rostered worker to supernumerary status for pre-registration students, affecting their experiences of both education and training during studentship.

Transition theories suggest that changes occur over time and longitudinal study designs which collect data at more than one point in time can indicate the direction of change, its causes and effects (Bowling 2014). This design was therefore a prerequisite for inclusion in this review to gain a full understanding of the changes over time that nurses experience when changing work roles. In addition, both pre-registration and post-registration nurses across all geographical locations were included to gain a comprehensive understanding of experiences and perceptions as well as all work roles that nurses might occupy (Arrowsmith *et al.* forthcoming).

**Table 3.1 Inclusion criteria**

<b>Inclusion criteria</b>
Published between January 1990 and October 2015
Longitudinal design
Empirical research
Data collected by any methods
Pre-registration nurses' experiences of role transitions
Post-registration nurses' experiences of role transitions

### **3.2.4 Exclusion criteria**

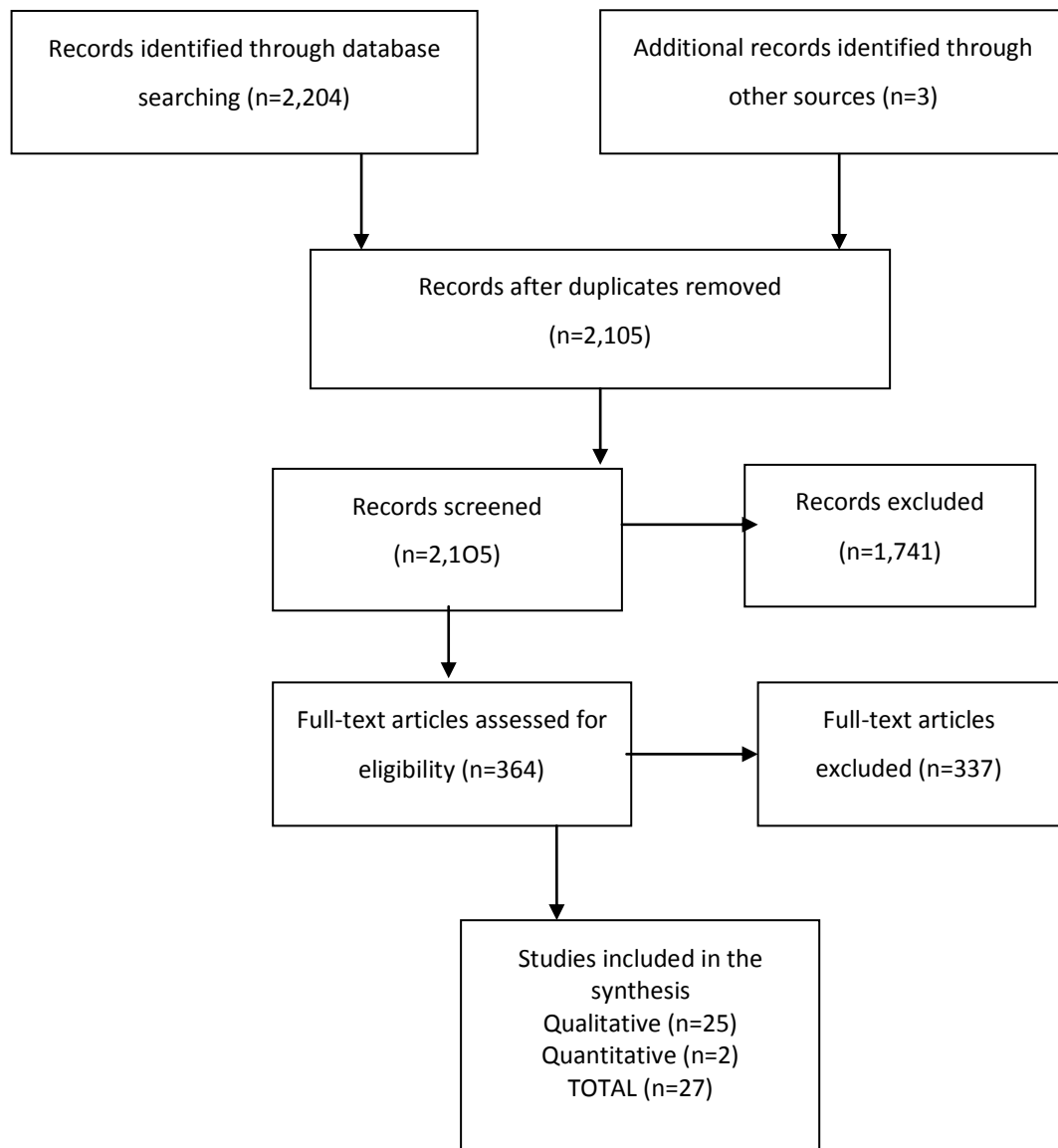
All the included studies are related to learning and many to formal educational programmes. However, evaluations of work-based and educational programmes whose primary focus are on the structures and processes which can act as facilitators and constraints to transitions were excluded because nurses' experiences of transitions were the focus of this review. The opinions of "observers" were also excluded on the same grounds. Observers included workers other than nurses, caregivers, patients and midwives. Cross-sectional studies were excluded because of their limited ability to chart change over time – a key characteristic of transitions. Non-empirical research studies, including editorials, brief items, conference paper summaries, tips and opinion pieces and policy documents, were excluded due to perceived lack of research rigour. Unpublished dissertations and theses were also excluded and instead their findings sought in the published literature.

**Table 3.2. Exclusion criteria**

<b>Exclusion criteria</b>
Data provided by workers other than nurses
Data provided by caregivers
Data provided by patients
Data provided by midwives
Cross-sectional studies
Editorials, brief items, conference paper summaries, tips, opinion pieces
Unpublished dissertations and theses
Policy literature
Evaluations of work-based programmes
Evaluations of educational programmes

### 3.2.5 Search outcome

The initial search located 2,204 references and three more were located through hand searches. After duplicates were removed 2,105 papers remained. A further 1,741 papers were excluded based on one or more of the exclusion criteria discussed above. Following these initial exclusions a total of 364 full-text papers were accessed, of which a further 337 were excluded after close reading. This left a total of 27 papers which met the inclusion criteria for the review (Figure 3.2). One included paper reported on part of a larger PhD study (Holt 2008), but a citation search revealed no further publications.



**Figure 3.2 Overall flow of the literature search**

### **3.2.6 Quality appraisal**

Adapted templates for “quantitative” studies were based on Long *et al.* (2002) and for “qualitative” studies Walsh and Downe (2005) (Appendices 3.1 and 3.2). The debate as to whether it is either possible or desirable to establish quality criteria for qualitative inquiry has ranged from positions which reject criteria altogether to those which support concepts common to both qualitative and quantitative data (Richie *et al.* 2003, Downe 2008). The approach adopted herein was not rigidly procedural and takes account of key features of the study (Guba & Lincoln 1981). It allowed the reviewer’s judgement to remain at the heart of quality considerations (Ritchie *et al.* 2003) and avoid a tick box approach. The papers were appraised as high, medium or low according to the quality criteria listed in the relevant template. In addition, the reviewer’s judgements on the relevance of each study to the review, appropriateness of the methodology and design, and topic focus (EPPI-Centre 2010) were taken into account (Appendix 3.3). A table summarising the quality assessment of all included papers was drawn up (Appendix 3.4). No studies were excluded on the basis of quality, but less weight was given in the discussion below to poorer quality papers (Jones *et al.* 2014).

### **3.2.7 Data abstraction**

Thematic abstraction and synthesis of the qualitative papers was undertaken by adopting the principles outlined by Thomas and Harden (2008). After quality assessment each paper was closely read and a three-part process of identifying themes was undertaken. These were not discrete steps, and overlapped to some degree, but nonetheless were characterised by three stages:

- 1 line-by-line coding of the findings of the primary studies
- 2 organisation of codes into related areas to construct descriptive themes
- 3 development of the descriptive themes into analytic themes.

This method draws on established methods and techniques commonly described as “thematic analysis” (Thomas & Harden 2008) and the bedrock is the identification of “repeatable regularities” (Miles & Huberman 1994, p. 64). Key concepts relating to the substantive meaning in the studies were identified and coded, then taken from one study and translated into others. They may not be expressed using identical words (Thomas & Harden 2008), though in this review most are. Codes and themes were taken from the “Findings” sections of the included papers but

“Discussion” sections and “Abstracts” were also checked for findings not presented elsewhere – though none were found in these sections of the reviewed papers.

For quantitative papers the data were abstracted and coded as for qualitative papers using the same principles (Thomas & Harden 2008). Codes were taken from the narrative descriptions of statistical analyses and inserted into a summary/matrix table (Harden & Thomas 2005) (Appendix 3.5).

### **3.2.8 Synthesis strategy**

The table summarising the papers (Appendix 3.5) created a matrix which facilitated constant comparative analysis (Harden & Thomas 2005) and movement back and forth between the qualitative and quantitative analyses. Findings from qualitative studies were distilled down to their essential features to form descriptive themes. This provided the mechanism for incorporating the quantitative findings which could be supplemented by additional codes and themes identified in the quantitative studies. Note was taken of matches, mismatches and gaps in the quantitative data codes when compared with the qualitative data codes and descriptive themes.

From the descriptive themes generated from the two data sets, analytic themes were inferred. The codes and themes which were generated when the findings from each type of study were first interrogated were re-examined, compared and contrasted, refined, then grouped into higher-order themes (Thomas *et al.* 2003, Thomas & Harden 2008). A small set of generalisations resulted which cover the consistencies discerned in the data (Miles & Huberman 1994). The process was guided by constant recourse to the questions underpinning the review to ensure that the perceptions and experiences of nurses’ work role transitions and their facilitators and constraints remained at the heart of the review. As Thomas and Harden (2008) suggest, this stage is the most difficult stage to describe since it is dependent on the judgement and insights of the reviewer.

## **3.3 Results**

### **3.3.1 Study characteristics**

Twenty-seven papers were included in this review, 25 qualitative and 2 quantitative. No experimental studies were found which met the inclusion criteria. Most studies were conducted in

one country (n=26) although one paper (Boychuck Duchscher 2009) draws on the data from four empirical studies, three in Canada and one from Australia. All studies were from “developed” nations: ten from North America, six from England, four from Sweden, three from Australia, and one each from Wales, Ireland and New Zealand. One study was from South Africa’s Cape Province, which the authors describe as a middle-income country. Only one paper attempted to track changes over more than one role change, and that from student to newly qualified to RN 3–5 years after graduation (Bjorkstrom *et al.* 2008). The numbers of participants in each study ranged from a case study of two participants (Glen & Waddington 1998) to Bjorkstrom *et al.*’s survey (2006) totalling 247 participants. Interviews of various kinds were the most common method of collecting data (n=21), although one study conducted both surveys and interviews (Ross & Clifford 2002), and two collected survey data only (Bjorkstrom *et al.* 2006, 2008, Deasey *et al.* 2011). However, the numbers of studies in the Deasey *et al.* study were reported as too low to convincingly demonstrate non-parametric tests associations. No studies were reported as mixed methods studies, although the two papers by Bjorkstrom *et al.* (2006, 2008) reported separately on the qualitative and quantitative findings of what appears to be the same study, and Ross & Clifford (2002) reported both forms of data in a single paper. Seven papers took a phenomenological approach, three ethnographic and three grounded theory, while the remainder of the qualitative papers were either case studies or described as “qualitative”. The large number of papers taking qualitative approaches reflects the strong tradition which prioritises perceptions, meanings and emotions (Silverman 2005) and which are congruent with the aim of this review.

Personal journals were analysed in six studies (Fagerberg & Ekman 1998, Glen & Waddington 1998, Kapborg & Fischbein 1998, Boychuck Duchscher 2001, Bombard *et al.* 2010). Job descriptions were analysed by Holt (2008) and Ross and Clifford (2002). Seng and Sanubol (2004) and Sullivan-Benz *et al.* (2010) analysed organisational documents, while two studies employed the observational method (Barton 2007, Holt 2008). Data collection periods ranged from three weeks (Godinez *et al.* 1999) to eight years (Bjorkstrom *et al.* 2006, 2008), and all studies tracked change over time.

Models of transition were proposed by Holt (2008) with respect to clinical role change in primary care settings, by Boychuck Duchscher (2008), Godinez *et al.* (1999) and Schoessler and Waldo (2006) for newly qualified nurses, and by Dearnley (2006) for transition from Enrolled Nurse to

RN, and by Brown and Olshansky (1997) from experienced to specialist nurse. In addition, Barton (2007) and Glen and Waddington (1998) suggest that generic models of transition (van Gennep [1909] 1960, Nicholson & West 1989) can explain the transitions of experienced nurses moving to specialist roles.

The summary of all papers which includes aspects of transition found in each paper provided a matrix from which to generate codes and descriptive and analytic themes (Appendix 3.3). An example taken from the summary/matrix table is provided below (Table 3.3).

**Table 3.3 Example from summary/matrix**

Author (year) Location	Role change	Design, methods and number (n) of participants	Summary of findings			
			Findings	Pathway	Aspects of transition codes: Perceptions and experiences	Aspects of transition codes: Facilitators and constraints
Barton T.D. (2007) Wales	Experienced to specialist nurse	Ethnography Interviews x2 over 2 years Field notes (n=21)	Themes: social; professional; clinical authority; clinical knowledge; clinical skills Reflects van Gennep's model – "Rites of passage"	Experienced nurse	Frustration Skills and competence Conflict Identity	Facilitators: role models and changing relationships with colleagues  Constraints: resistance and hostility from colleagues New role unacknowledged

### 3.3.2 Pathways

Pathways through the process of transition were found to be traversed by two groups of nurses. The first is novice nurses and the second is experienced professionally qualified nurses (Table 3.4). Novice nurses comprise pre-registration students (n=4) and newly qualified nurses (n=13). The second group are experienced nurses who comprise: Enrolled Nurse/Licensed Practical Nurse to RN (n=3); clinical role change (n=1); and experienced to specialist (n=6). No papers which met the inclusion criteria were found charting the transition of experienced nurse from clinical nurse to nurse manager, or from clinical to academic nurse.



**Table 3.4 Pathways through work role transitions**

Pathway	Group
Novice (n=17)	Pre-registration student nurses (n=4) Newly qualified nurses (n=13)
Experienced (n=10)	Enrolled/Licensed Practical Nurse to Registered Nurse (n=3) Clinical role change (n=1) Experienced to specialist (n=6)

**3.3.3 Analytic themes**

The codes were taken directly from the data and grouped into descriptive themes which stay close to the data. The included papers were then re-examined alongside the descriptive themes and possible analytic themes were inferred with constant recourse to the review questions (Section 3.1). Through further review more abstract analytic themes began to emerge and the processes were repeated until three overarching analytic themes were identified which were sufficiently abstract to explain/describe the descriptive themes and the codes (Thomas & Harden 2008) (Table 3.5).

**Table 3.5 Analytic and descriptive themes and codes**

Analytic themes	Descriptive themes	Codes
1 Striving for a new professional self	i) Emotional upheaval	Stress, anxiety, fear Frustration, disappointment, dissatisfaction Shock Excitement
	ii) Identity	Reference group Attitudes and values
2 Know-how	i) Competence	Skills for nursing practice Confidence
	ii) Boundaries	Blurring and uncertainty Conflict
3 Learning circumstances	i) Support roles: formal and informal	Preceptors, mentors, experienced staff, leaders, managers, peers
	ii) Workplace relationships	Acceptance, resistance, hostility, role unacknowledged, fitting in, lack of: understanding, autonomy, authority, feedback
	iii) Workplace organisation	Support of work role change programmes, workload, supernumerary status, clinical rotations, lack of resources, demands, local/provincial legislation and regulations,

		development opportunities, career pathways
	iv) Education and support programmes	Induction/orientation programmes, reflective practice, lifelong learning skills, theory–practice gap, skills and knowledge for practice

### 3.3.4 Theme 1: Striving for a new professional self

The journey through transition involves change, with nurses struggling to compose a new professional self. As they wrestle to reshape their identity, both experienced and novice nurses encounter emotional upheaval. These feelings include: stress, anxiety, fear, frustration, disappointment, dissatisfaction and shock. There is also some evidence of alternative feelings, for example feelings of excitement and of exhilaration (Boychuck Duchscher 2008), but the overwhelming emotions found in all pathways are tied to feelings of discomfort.

#### ***Emotional upheaval***

##### *Stress, anxiety and fear*

Novice pre-registration nurses report stress, anxiety and fear. Fagerberg and Ekman's study (1998) followed 27 student nurses across their entire three-year programme and found that anxiety, stress and fear are most evident prior to registration and the prospect of taking up the role of RN.

Novice newly qualified nurses also feel stressed, anxious and fearful (Walker 1998, Boychuck Duchscher, 2001, 2008, Ross & Clifford 2002, Rungapadiarchy *et al.* 2006, Schoessler & Waldo 2006). Backed by evidence from a series of four Canadian studies over a ten-year research programme into newly qualified nurses' work role transitions, Boychuck Duchscher (2008) describes nurses as stressed about "absolutely everything" including caring for clinically unstable patients, multi-tasking, applying skills to clinical contexts, failure and incompetence. These novices were also fearful of disappointing, family, friends and colleagues, as was also found by Walker (1998), Schoelssler and Waldo (2006) and Roziers *et al.* (2014). Schoessler and Waldo (2006), reporting from the USA, found newly qualified nurses stressed, and fearful of patients asking questions they could not answer. However, the design of the study and the analysis procedures were not clearly described. In South Africa Roziers *et al.* (2014) found that prior to taking up their first role, newly qualified nurses experienced anticipatory fear and uncertainty

regarding dealing with conflict, managing a ward and delivering care. Interestingly, none of the eight participants recorded fear or anxiety about increased responsibility.

Newly qualified nurses are also anxious and fearful of causing harm to patients, particularly through medication errors (Ross & Clifford 2002, Rungapadiarchy *et al.* 2006, Boychuck Duchscher 2008). Ross and Clifford (2002) collected data in the UK pre- and post-registration, with the aim of comparing expectations and experiences of transition. Their study generated both qualitative and quantitative data but reported only the “qualitative” data. Post-qualifying survey took place but not the interviews that were planned. However, the findings are explained and justified in some detail, but the lack of comparative data limits findings. Rungapadiarchy *et al.* (2006) report on 11 semi-structured interviews which took place six months post-registration in the UK. Findings from pre-registration interviews are not reported, although the emergent themes from the second post-registration interviews are, and in some detail. These UK studies, together with Boychuck Duchscher’s Canadian study, suggest fear of harming patients is common in neophyte nurses.

Post-registration transition experiences were studied by Walker (1998), who conducted two focus groups at four and nine months post-registration with five nurses in New Zealand. This study found nurses stressed and anxious about meeting the expectations of health professionals, clients and themselves. This claim, supported by verbatim quotes, mirrors Schoessler and Waldo’s (2006) findings that newly qualified nurses feel angry and anxious when trying to live up to expectations. In addition to their professional work stresses, anxieties and fears, Boychuck Duchscher (2008) reported that newly qualified nurses’ anxiety was related to changes in their personal relationships and financial commitments. In contrast Roziers *et al.* (2014) reported nurses enjoying increased time with family and friends as they did not have to devote time to study.

The paper by Etheridge (2007) reported on newly qualified nurses who took part in an intern programme and were interviewed three times in eight to nine months. However, the sample, the procedure for sampling and the inclusion/exclusion criteria were not described and the number of participants is not clear, which significantly reduced the extent to which the claims made could be viewed as sufficient and generalisable. Also, the paper by Schoessler and Waldo (2006) likewise

did not record the number of participants, the sampling procedure or the time points over the first 18 months in practice when the interviews were recorded, again reducing the overall quality of the paper. However, these two papers (Schoessler & Waldo 2006, Etheridge 2007), together with the previous studies (Rungapadiarchy *et al.* 2006, Ross & Clifford, 2006, Boychuck Duchscher, 2008, Roziers *et al.* 2014), provide evidence that stress is present when student nurses transition to the role of Staff Nurse. This wide range of studies on newly qualified nurses demonstrates that across various geographical locations and points in time the initial experiences of being a nurse are stressful and linked to anxiety and fear. This stress is associated not only with caring for patients but also with their personal feelings about themselves when taking up the new role.

Experienced nurses can also experience stress associated with anxiety and fear and the ability to function within the role. A small study conducted in Australia analysed the data from three focus groups which took place over 12 months as former Enrolled Nurses studied to become RNs (Cubit & Lopez 2012). It found the process of transition to be characterised by worry and anxiety as students struggled to take up their new role. Sullivan-Benz *et al.* (2010) presented further evidence that stress, anxiety and fear are present when experienced nurses change work roles. They reported that Canadian nurses moving to the role of Nurse Practitioner initially felt overwhelmed and stressed before becoming confident in their abilities. Similarly, Brown and Olshansky (1997), in a small high-quality study conducted in the USA, found that nurse practitioners initially felt like imposters and anxious about their performance and their abilities. Like newly qualified nurses they too feared making mistakes. However, they were able to use their problem-solving skills to confront the anxieties they experienced. The ability to utilise already existing skills is also evident in a study in the USA by Seng and Sanubol (2004). In a well-evidenced paper they explained that experienced nurses found the transition to sexual assault nurse not as stressful as they had anticipated. They described the experience as more akin to role expansion rather than transition because as experienced nurses they had many prerequisite skills for the new role in place. They did experience nerve-racking stress at being on call, but reported that they already had mechanisms in place to deal with stress. Rather worryingly, they also reported that work life tipped over into home life; they feared reprisal by perpetrators on their families and friends.

Experienced nurses, therefore, like learner nurses, feel stressed when they change work roles. Both groups of nurses feel anxious and nervous about their ability to function in the role and fear harming patients, thereby linking the theme of stress to that of competence. However, as Seng and Sanubol (2004) and Brown and Olshansky (1997) indicate, experienced nurses can draw on their prior experience to ease the stress of transition and its associated anxieties and fears.

### *Frustration*

Frustration was noted in a number of studies related to the emotional upheaval experienced when nurses strive for a new professional self. Rungapadiachy *et al.* (2006, p. 536), in a well-evidenced study in the England, found that mental health nursing students were frustrated that it was “almost impossible” to challenge mental health practices. However, it is not the sole preserve of students to feel frustration. A number of studies involving experienced nurses moving into a variety of specialist roles indicate frustrations were present. For these nurses the issues are linked to resistance and hostility towards the new roles and to inter-professional relationships. For example, Glen and Waddington (1998) reported a case study of two Staff Nurses who moved to the role of Clinical Nurse Specialist (CNS). The sampling and analytic procedures were unclear but findings indicate that these nurses encountered resistance to change from nursing and medical colleagues, leaving them feeling stressed and frustrated. Bombard *et al.* (2007) reported on four nurses training to be Clinical Nurse Leaders in the USA and, although the procedure for analysis was unclear, findings suggest these nurses were also frustrated by the lack of role recognition by colleagues. Barton (2007), reporting on ten student nurse practitioners in Wales, presents good evidence that they felt they were perceived by colleagues as a threat. As a result they were in a state of limbo due to resistance and hostility in the workplace. Although the numbers of participants in these studies of experienced nurses are not high, together findings indicate that experienced nurses can be frustrated and stressed by colleagues’ attitudes and behaviours when moving to new, more advanced roles.

### *Shock*

The most extreme form of emotional upheaval found in this analysis of nurses’ work role transitions is that of shock. Two types were found: reality shock and transition shock. The term “reality shock” was coined by Kramer (1974); it relates to how educational values conflict with the

world of work values and describes staff who believed that they were prepared for a work situation only to find they were not.

Reality shock is evident in studies of newly qualified nurses. Kapborg and Fischbein (1998) ascribed reality shock to Swedish nursing students experiencing the transition to the role of “professional nurse”. Walker (1998), also in the context of newly qualified nurses but in New Zealand, suggests strategies exist to ameliorate the effects of “reality shock” but does not enlarge on this. However, Schoessler and Waldo (2006) reported newly qualified graduate nurses’ feelings of fatigue, perceptual distortions and moral outrage. Their struggles were initially personal then became concerned with the workplace organisation, and the authors suggest these are consistent with Kramer’s reality shock. Newton and McKenna (2007) found that reality shock existed in their study of Australian nurses and this 40 years after Kramer’s study was first published, indicating the issue has still not been addressed. Other studies, while not using the term reality shock as proposed by Kramer (1974), do highlight the shock experienced when discussing how preparation for the role does not support ease of transition. For example, and again with respect to newly qualified nurses, Rungapadiachy *et al.* (2006) report that nurses felt there was no place for the skills they learned during training and little understanding of evidence-based practice in practice settings, indicating a “theory–practice gap” (p. 537) akin to reality shock, though not explicitly articulated.

There is some evidence in this review that disappointment and dissatisfaction are a part of the shock that newly qualified nurses experience. For example, Boychuck Duchscher (2001; 2008) found they experienced disappointment related to institutional rules and practices and disappointment and guilt at not being capable of doing more. Kapborg and Fischbein (1998) analysed eight diaries written by purposely selected newly qualified nurses over two months. They found dissatisfaction among the nurses because they felt unable to master the whole of the situations they were confronted with. Ross and Clifford (2002) also found newly qualified nurses disappointed, dissatisfied and disillusioned with their experience of being a nurse. One participant in their study was reported to leave her post within three months because of the traumatic experience of transition.

A study in England (Gerrish 2000) of neophyte nurses with two different educational preparations for the role of RN found that both groups experienced shock when first practising as a qualified nurse. It was concluded that this was an inevitable result of the inability to be exposed to the realities of the role until it is taken up. In contrast, Roziers *et al.* (2014) recorded that while South African nurses do experience reality shock, this is tied to poor staff attitudes, being expected to care for acutely ill patients and uncertainty about their new residences and finances.

Boychuck Duchscher (2001, 2008, 2009), in the comprehensive research programme spanning ten years and four different studies, proposes “transition shock,” describing it as the most immediate, acute and dramatic stage in the process of moving from student to Staff Nurse. Loss, doubt, confusion and disorientation associated with knowledge, responsibilities and relationships were highlighted and a conceptual model proposed including, physical, emotional, intellectual and social–developmental aspects. It is explained as a model which “builds on elements of transitions theory, reality shock, cultural and acculturation shock as well as theory related to professional role adaptation, growth development and change” (Boychuck Duchscher 2009, p. 1111).

The papers in this review pertaining to experienced nurses’ changing work roles, and pre-registration students being educated to be a nurse, were found not to be associated with shock or disappointment and dissatisfaction. However, there are a range of papers from a range of geographical areas, and time points, which report the “reality shock” newly qualified nurses experience when they take up their new role as a nurse. In addition, “transition shock” is entirely associated with the experiences of newly qualified nurses. This indicates that the shock, while clearly evident in the literature, is almost exclusively tied to the experiences of newly qualified nurses.

### *Excitement*

Alongside feelings of discomfort, some limited evidence exists of more comfortable feelings and emotions, especially at the outset of transition experiences. Boychuck Duchscher (2008) reported that newly qualified practitioners were initially excited about the transition from student to professionally qualified nurse. However, they quickly realised that they were unprepared for their new role, although by the 12-month marker all had reached a stable level of comfort and

confidence. In addition, Roziers *et al.* (2014) reported that newly qualified nurses experienced a short-lived sense of achievement.

The papers above, positioned as they are over a range of geographical areas, time spans and work roles, indicate that emotional upheaval is a ubiquitous experience for all nurses experiencing work role transition. However, while emotional upheaval is evident across all groups of nurses it is most prominent in papers reporting on newly qualified nurses' transitions. Evidence from a range of studies (Brown & Olshansky 1997, Fagerberg & Ekman 1998, Godinez *et al.* 1999, Ross & Clifford 2002, Schoessler & Waldo 2006, Barton 2007, Boychuck Duchscher 2008, Roziers *et al.* 2014) indicate that, across time and a variety of geographical locations, stress is present in these novices. Moreover, newly qualified nurses alone experience shock: reality shock and transition shock. Experienced nurses and pre-registration nurses in this review were found not to be subject to this extreme emotional upheaval. In addition, well-evidenced papers (Deasey *et al.* 2011, Glen & Waddington 1998, Melrose & Gordon 2011, Seng & Sanubol 2004) found that prior experience of the work context and utilising existing skills facilitated ease of transitions and mitigated stress.

### ***Identity***

Striving for a new professional identity is associated not only with emotional upheaval, but also, according to Holt (2008), with education and learning as well as physical, psychological and social aspects of role change. It includes changes in attitudes and values, and when identity changes old values are lost. Further, Holt suggests an individual's identity in the workplace is not left at work but is an intrinsic component of their personal life and home identity, and that boundary crossing supports the notion of coexisting identities. Boychuck Duchscher (2001) explains that a job provides identity as it links individuals to society and to social networks and one perceives one's own identity relative to those with whom one associates.

### ***Reference group***

In this review identity was found tied to how nurses perceived themselves relative to colleagues, their reference group. This was evident in a range of papers across geographical areas and nurses' work role transitions, and can involve struggle and conflict.



Striving for a new professional self for novice pre-registration nurses involves gaining a new identity as a student nurse (Bjorkstrom *et al.* 2006, 2008). Reporting, again from Sweden, Fagerberg and Ekman (1998) found that student nurses in the group who were formerly Licensed Practical Nurses experienced a conflict of identity and loyalty vis-à-vis their former colleagues. Moreover, identification as a nurse was found to be an issue of key importance for both students with former experience and those without. An important influence on developing a nurse's identity was acceptance by members of the health care team.

Novice newly qualified nurses also struggle to find a new identity and one which accords with that of registered nurse colleagues (Boychuck Duchscher 2008). Kapborg and Fischbein (1998) agree, suggesting that novices are left to search for a self-concept as a registered nurse and they link this difficulty to the theory–practice gap. Godinez *et al.* (1999) found that newly qualified participants initially no longer felt like student nurses but had not yet fully taken up the identity of a nurse. Etheridge (2007) reports that learning to think like an RN involves self-awareness and a belief in one's ability to be competent, accountable and responsible. Schoessler and Waldo (2006) suggest that identity as a nurse is confirmed when the newly qualified nurse feels part of the team, and when new nurses asked them questions that they are able to answer.

As newly qualified nurses seek a new professional identity the transition is characterised by discomfort (Kapborg & Fischbein 1998, Godinez *et al.* 1999, Boychuck Duchscher 2008, Roziers *et al.* 2014). The ability to perform competently in the role (Kapborg & Fischbein 1998) and acceptance by other nurses confirms identity change (Fagerberg & Ekman 1998, Schoessler & Waldo, 2006).

Experienced nurses' transitions were also found to be difficult experiences as nurses strive for a new professional identity. Brown and Olshansky (1997), reporting from the USA on 35 new Nurses Practitioners, were surprised by the depth of difficulty nurses' experienced. A four-stage model was produced explaining the transition as a period of identity confusion, firmly linking identity to processes of transition. Barton (2007), reporting from England, also identifies the link, finding that student nurse practitioners experience loss of identity, and this stage of transition is marked by professional and clinical limbo. Barton (2007) found that students re-evaluated their role, became disengaged then separated from the old role, which in turn led to a new clinical

identity. However, maintaining a dual role of worker and student perpetuated the difficulties inherent in the process of finding and adopting a new identity.

The ability to practise autonomously and independently of superiors was found by Glen and Waddington (1998) to be an important aspect of Clinical Nurse Specialists' (CNS) development of a new identity. The sampling and analytic strategies were unclear but they found that locating oneself within the organisational context and establishing an altered self-image, as well as developing new interpersonal relationships, was important for identity reformation. Similarly, in a study of 11 registered nurses changing their work roles in UK community health settings, Holt (2008) identified four concepts of transition: centring identities; focusing roles; enacting roles and shaping roles. Identity was regarded by the participants in this study as being the role, the person and part of a group. These studies of experienced nurses link changed identity to new roles, to colleagues as reference groups, and to the workplace.

An interesting study conducted in the USA demonstrates that the transition to a proposed new identity is not always achieved (Bombard *et al.* 2010). Students who participated in a programme to prepare them for Clinical Nurse Leader (CLN) roles were direct entry masters students who had approximately eight months of clinical practice experience prior to starting the programme and its clinical practicum. Perhaps unsurprisingly, they found the practicum stressful and confusing and felt that their lack of clinical experience was a major drawback to developing the CNL role. Links between the themes of stress, competence and identity are demonstrated in this study. Moreover, after a year of professional practice these nurses were still reporting confusion and uncertainty within themselves and felt by colleagues. The question "what is a CNL?" persisted, according to the author-participants, even as the paper was published. The difficulties and struggles remained and were seemingly unresolved.

#### *Attitudes and values*

Striving for a new professional identity can also involve changes in attitudes and values. Bjorkstrom *et al.* (2006, 2008) found that the ability of student nurses to demonstrate awareness of basic values was related to developing a professional identity and this continued to develop post-registration. Fagerberg and Ekman (1998), again of Swedish student nurses, reported that

increased knowledge increased understanding of themselves as human beings, which implies an awareness of attitudes and values.

Etheridge (2007) reported on newly qualified nurses in the USA. Interviews were conducted at one month, two to three months and eight to nine months after graduation. Numbers of participants in the study are not given, but the theme identified of “Learning to think like a nurse” includes self-awareness and a belief in one’s ability for competence, accountability and learning responsibility. This describes the development of an identity bound up with attitudes and values and beliefs, but also demonstrates the tie between identity and competence. Glen and Waddington (1998), in the UK and also reporting on newly qualified nurses, state that adopting new values was a stage in organisational socialisation and role transition.

The literature on student nurses with prior nursing experience also demonstrates an association between identity and attitudes and values. Melrose and Gordon (2011) reported from Canada that the primary motivation for Licensed Practical Nurses undertaking a Bachelor of Nursing programme was to fulfil personal learning goals rather than financial considerations, indicating the value they placed on education. Dearnley (2006), reporting in England on second level nurses (Enrolled Nurses) moving to first level (RN), found changes took place over time, including their outlook on the profession, their personal lives and the way in which they embraced the philosophy of lifelong learning. This study also indicates that attitudes and values are associated with the identity of an RN.

Identity linked to attitudes and values has been discussed above in relation to pre-registration student nurses, newly qualified nurses and experienced Enrolled Nurse/Licensed Practical Nurses studying to move from second to first level registration. However, the literature on experienced RNs does not discuss their attitudes and values.

### **3.3.5 Theme 2: Know-how**

The second analytic theme of “Know-how” is concerned with applying the skills of nursing in actual clinical situations. It is associated with competence in the application of skills and with confidence to do so. It is also concerned with knowing the extent and limits of the professional and practice boundaries associated with the new role.

Across a range of skills: assessment and intervention; communication; critical thinking; caring skills; management skills; and knowledge integration, the studies in this review highlight the importance both novice and experienced nurses ascribe to knowing how to apply skills (Dufault 1990, Brown & Olshansky 1997, Fagerberg & Ekman 1998, Glen & Waddington 1998, Kapborg & Fischbein 1998, Walker 1998, Godinez *et al.* 1999, Gerrish 2000, Seng & Sanubol 2004, Barton 2007, Bjorkstrom *et al.* 2006, 2008, Dearnley, 2006, Schoessler & Waldo 2006, Melrose & Gordon 2011).

### ***Competence***

Competence has been defined as a generic ability that transfers across settings and situations with the ability to perform effectively on different occasions and in different contexts (Deback & Mentkowski 1986). In a concept analysis Garside and Nhemachena (2011) found competence to be an extremely nebulous concept, defined by different people in different ways, but firmly rooted in the measurement of RNs' ability to perform effectively. They conclude that there are so many definitions of competence that all one can say is that the conundrum of what competence is is compounded by the multitude of definitions. Nevertheless, in this review competence was found to be associated with two broad subthemes: skills and confidence.

### ***Skills for nursing practice***

The skills found in this review encompass a range of technical and practice skills including: assessment and intervention; communication; management; leadership; teaching; and linking theory to the practice of nursing.

Assessment and intervention skills were evident in a number of studies and included the technical aspects of nursing practice. Godinez *et al.* (1999) note that newly qualified nurses in the USA who completed feedback sheets over three weeks perceived that acquisition of technical and physical skills was important to make the transition to RN. Schoessler and Waldo (2006, p. 51), also from the USA, go further, noting that the transition to RN is marked by movement from task orientation to achieving patient goals in "competent practice". Kapborg and Fischbein (1998) found that newly qualified nurses felt they lacked competence in a range of skills, including caring for dying people. Schoessler and Waldo (2006) and Godinez *et al.* (1999) report that coping with death and

mastering new skills were important hallmarks in the transition to the role of RN. Rungapadiarchy *et al.* (2006), reporting on newly qualified mental health nurses in England, also note the significance of acquiring relevant skills to fulfil the requirements of a new role. Nurses reported that they felt they lacked competence in skills including administration of medications, as did Diploma-prepared nurses in Gerrish's (2000) survey. In contrast, Kapborg and Fischbein (1998), in Sweden, found that none of the newly qualified nurses in their study described problems related to drug calculations.

Experienced nurses also report on the need to acquire a range of assessment and intervention skills for developing competence in nursing practice. For example, Seng and Sanubol (2004) discuss experienced nurses developing new skills in examining and reporting on sexual assaults, and Barton (2007) records that Nurse Practitioner students sought to acquire competence, for example, to assess the relative importance of blood results. Brown and Olshansky (1997) noted that Nurse Practitioner students in the USA also worried about acquisition of clinical skills, but that the assessment skills of these experienced nurses were already developed and that in their initial practice they were already competent in this respect.

All groups of nurses, newly qualified and experienced, perceive that the acquisition of assessment and intervention skills to fulfil the demands of the new role is an important step in developing competent practice. However, Brown and Olshansky (1997) interviewed 35 nurses at three points over 12 months and, although the sampling strategy was unclear, the study provides some evidence that experienced nurses already have some skills in place to meet the demands of new roles. Seng and Sanubol (2004) also found this of nurses who trained as sexual assault nurses, particularly when their prior experience was in obstetrics/gynaecology or emergency care. These experiences contrast with novice nurses, who may not have sufficient skills to draw on to ease their transition. For example, the 11 newly qualified nurses in Rungapadiarchy *et al.*'s (2006) study felt incompetent in a range of mental health-specific therapeutic interventions such as cognitive behavioural therapy, play therapy and graded activity.

Communication skills were also found to be associated with the theme of competence. Fagerberg and Ekman (1998) reported on Swedish pre-registration students' knowledge and competence over the three years of their education and training. They found that students developed

competence in communicating patient needs to team members, physicians and patients, families and next of kin and this skill developed over the programme span. However, this same group worried about a lack of empathy with some patients.

Walker (1999), reporting on newly qualified nurses in New Zealand, also found that communication skills developed over time. However, Kapborg and Fischbein (1998) found that newly qualified nurses' communications with patients and relatives could be problematic, for example, breaking bad news. They also found that new nurses experience communication difficulties, not knowing what kinds of tasks they could delegate to assistant nurses, as did Boychuck Duchscher (2008) and Gerrish (2000). In contrast, Deasey *et al.* (2011) conducted a survey and reported that 96 newly qualified nurses in Ireland felt competent in delegating care to colleagues and felt they had effective interpersonal skills.

The literature on communication skills has found that they are a concern of novice nurses, both pre-registration and newly qualified. In contrast, experienced nurses' communication skills were not reported in the papers included in this review.

Two papers were found in this review to be associated with critical thinking, both in relation to newly qualified nurses. Both papers link critical thinking with workload priorities. Kapborg and Fischbein (1998) reported that nurses were unsure when to call a physician and this impacted on how they prioritised their workload. Etheridge (2007) highlights how newly qualified nurses learn to think critically; putting information together and knowing what it means and then re-prioritising tasks.

Management competences are more widely reported in the papers in this review than either critical thinking or humanistic caring skills. Boychuck Duchsher (2008) reported that newly qualified nurses who were stressed would delegate inappropriately, but they experienced a consistent and rapid advancement of their thinking, knowledge levels and skills competences over the first 12 months of post-qualifying practice. Time management and managing workload were found to be a particular problem for newly qualified nurses (Gerrish 2000, Schoessler & Waldo 2006, Kapborg & Fischbein 2007, Newton & McKenna 2007). However, in contrast, Deasey *et al.* (2011) found that newly qualified nurses perceived themselves as competent across a range of

domains including time management and managing their workload. There is also some evidence that experienced nurses can find time management and workload an issue, as Glen and Waddington (1998) found of Staff Nurses transitioning to CNS roles. In addition, Melrose and Gordon (2011) reported from Canada on the transition that ten Licensed Practical Nurses experienced when studying for a Bachelor of Nursing qualification. The students found balancing full-time employment with the requirements of the educational programme very challenging. Time management strategies included terminating their full-time employment. Together these studies suggest that time management and managing workload can be an issue for both newly qualified and experienced nurses.

Developing competence in particular management skills was also found in this review. For example, Kapborg and Fischbein (1998), in relation to newly qualified nurses, and Rungapadiachy *et al.* (2006) report on difficulties in dealing with documentation. Bjorkstrom *et al.*'s (2006) research identified a major category, "competence and skills", and found that when knowledge increased nurses became confident leaders. Roziers *et al.* (2014) found that newly qualified nurses experienced difficulties in managing staff conflicts, dealing with difficult colleagues and delegating.

Being competent in linking theory to practice was acknowledged as important by nurses in a number of studies. Fagerberg and Ekman (1998, p. 617) record that pre-registration nursing students' ability to integrate theoretical and practical knowledge opened up the possibility of providing more "advanced care". Novice newly qualified nurses studied by Etheridge (2007) commented that being in the clinical setting enabled correlation of classroom learning with actual nursing practice. Experienced nurses also note the importance of knowledge integration into nursing practice. In a study of students with prior second level (Licensed Practical Nurse) experience, Melrose and Gordon (2011) found that mentors were needed to help students apply their learning to practice. Dearnley (2006) conducted 58 interviews over two years with students who had prior Enrolled Nurse experience. She found that students who were able to integrate theory and practice became a "dynamic practitioner" (Dearnley 2006, p. 214). Barton (2007) noted that knowledge of physiology and pharmacology was needed when qualified nurses transition to nurse practitioner roles.

These studies (Fagerberg & Ekman 1998, Etheridge 2007, Dearnley 2006; Barton, 2007; Melrose & Gordon, 2011) together demonstrate, for all groups of nurses from novice to experienced, the importance placed on integrating theoretical with practical knowledge to develop competent practice.

One study spanned the novice/experienced nurse continuum and a range of skills. In Bjorkstrom *et al.*'s study (2006, 2008) of 164 Swedish nurses, survey data were collected three times: at the beginning of pre-registration education, just before graduation and three to five years post-qualifying. Sixty-four informants participated in all three data collection times and this was the only study reviewed which attempted to study work role transitions from pre-registration to experienced nurse. The data were analysed using parametric and non parametric procedures (Bjorkstrom *et al.* 2008), and content analysis (Bjorkstrom *et al.* 2006). Results from the content analysis indicated that being competent and skilled emerged as a main category, and these elements increased over time. The questionnaire included 19 items from a validated instrument selected to cover a wide range of professional competences such as communication, leadership, teaching and research as well as items relating to personal and professional development. The authors added one item to the questionnaire – “practical skills”, which they did not define. Together all items in the questionnaire indicate that developing a range of skills for nursing practice is considered an important hallmark in the transitions nurses experience as they change roles, not just pre-, but post-registration too.

The acquisition of skills to fulfil the demands of the new role is an important step in developing competent practice noted in a range of high-quality papers on novice nurses (Brown & Olshansky 1997, Walker 1998, Kapborg & Fischbein 1998, Bjorkstrom *et al.* 2006, 2008, Rungapadiarchy *et al.* 2006, Newton & McKenna 2007) and papers reporting on experienced nurses (Glen & Waddington 1998, Barton 2007, Sullivan-Benz *et al.* 2010). However, some evidence suggests that experienced nurses already have clinical skills in place to meet some demands of new roles (Brown & Olshansky 1997, Seng & Sanubol 2004). This contrasts with novice nurses, who may not have sufficient skills to draw on to ease their transition (Brown & Olshansky 1997, Kapborg & Fischbein 1998, Walker 1998, Bjorkstrom *et al.* 2006, 2008, Rungapadiarchy *et al.* 2006, Schoelssler & Waldo 2006, Newton & McKenna 2007, Boychuck Duchscher 2008, Bombard *et al.* 2010, Roziers *et al.* 2014).



## **Confidence**

Confidence is associated with competence and Etheridge (2007, p. 25) states “confidence is a belief in oneself, one’s judgement and psychomotor skills, and in one’s own abilities to think and draw conclusions”. Fagerberg and Ekman (2007) found that pre-registration nursing students’ self-confidence increased when knowledge and technical skills increase. This finding is supported by the presentation of the narratives from two students who illustrate contrasting degrees of self-confidence over the three years of their pre-registration studies. There is also evidence from newly qualified nurses that confidence is linked to competence in the practice of nursing. Boychuck Duchscher (2008) found a crisis of confidence after seven months of registered practice relating to nurses feeling incompetent and letting patients and colleagues down. However, gradually these newly qualified nurses became more confident in their role and by six to eight months post-orientation a new-found liberation was experienced as they began to develop their practice and career goals. After 12 months this group reached a relatively stable level of comfort and confidence in their skills.

Godinez *et al.* (1999), also reporting on newly qualified nurses, also links confidence to competence, suggesting that competence combined with preceptors’ approval led to increased confidence. An interesting study conducted in England compared the experiences of student nurses pre- and post-implementation of Project 2000 when nurse education moved into Higher Education and students were deemed supernumerary in clinical practice (Gerrish 2000). Findings indicate that both the 1985 and 1998 groups felt inadequately prepared for the role of Staff Nurse, that the 1985 group were less confident in their management skills but the 1998 group were less confident in administration of medicines. Both groups experienced difficulties in decision making but the 1998 group had developed a more active learning style.

The element of confidence and its close relationship to competence is further evident not just in novice nurses’ transitions but also when experienced nurses change roles. Brown and Olshansky (2007) found that Nurse Practitioner students experienced a dynamic interrelation between competence and confidence and Dearnley (2006), reporting on Enrolled Nurse to RN, found that students lacked confidence in their ability to learn and were “silenced by the fear of not knowing” (Dearnley 2006, p. 213), but over time learned the importance of evidence-based practice. They

also came to trust their own judgements and subsequently experienced a growth in professional confidence. Dearnley (2006) suggests that acquiring skills of reflection aided this transition.

It is evident therefore in this review that competence is a theme which can be located throughout the literature and across various work role transitions that nurses experience. It is closely associated with a range of skills for nursing practice and with confidence in the ability to function in the new role. In line with the literature on transitions, this range of literature taking longitudinal approaches also indicates that change occurs over time. Competences and confidence change and increases when nurses successfully move from one work role to another or, as is the case with novice nurses, learn to become a nurse.

### ***Boundaries***

As new skills, competences and confidence are gained, “know-how” is also associated with knowing the extent and limits of the professional and practice boundaries associated with the new role. According to Abercrombie *et al.* (2006), there are social processes which maintain both the boundaries and the equilibrium of the system which constitute the environment. In the health care environment work role boundaries, as noted in Chapter 2, are subject to constant redefinition and reappraisal (Kessler *et al.* 2010, UNISON 2010). In this review, perhaps unsurprisingly, boundary uncertainties and blurring as well as conflicts were found to feature in experienced nurses working within the constantly shifting landscape of health care practice, as well as newly qualified nurses.

### ***Blurring and uncertainty***

When newly qualified nurses transition to the role of Staff Nurse, Boychuck Duchscher (2009) discusses the issue of marginalisation as nurses move from the centre of one cultural group (student nurse) to another (RN). The borders are seen as mutually exclusive, but also permeable. Blurring and uncertainty of boundaries are evident in a number of studies included in this review, with newly qualified nurses reporting not being clear about what their role entails (Godinez *et al.* 1999, Ross & Clifford 2002, Rungapadiachy *et al.* 2006, Etheridge 2007, Roziers *et al.* 2014). In the USA Etheridge (2007) and Godinez *et al.* (1999) reported that newly qualified nurses feel uncertain and need to learn about the role components that are unique to the institution they work in. Likewise in England, Ross and Clifford (2002) found that nurses expressed uncertainties. Their study data were collected pre- and post-registration and the need for clarification of roles was

identified. Also in England, Rungapadiarchy *et al.* (2006) also found blurring and uncertainty around role boundaries. Participants in this study perceived the role of the mental health nurse to be unclear and dependent on the clinical environment, individual mental health nurses and individual patients: “the role depends on where you are working” (Rungapadiarchy *et al.* 2006, p. 536).

### *Conflict*

Boundary conflicts were reported by Schoessler and Waldo (2006) to arise when newly qualified nurses encountered patients and families in new ways and at new emotional levels. Similarly, newly qualified mental health nurses experienced conflict in their new role, not certain if their duty of care took precedence over their role as an advocate, and uncertain if they were “advocate or bouncer” (Rungapadiachy *et al.* 2006, p. 536).

Conflict was particularly evident in studies of experienced nurses where professional boundaries were changing. Barton (2007) found conflict when resistance and hostility was encountered by ten experienced Welsh nurses as they began to establish the new role of nurse practitioner. This entailed crossing professional boundaries, undertaking roles and responsibilities traditionally seen as in the medical domain which required negotiations with not just medical colleagues but also their own professional peers. Barton suggests that when traditional boundaries are confronted there is a risk of censure due to social and cultural transgression. The troublesome issue of duality was also recognised by Barton. Nurses taking part in this study worked part time as a student nurse practitioner and part time in their old role, creating role boundary blurring and conflict. Glen and Waddington (1998), in England, report similar issues and found role boundary conflicts and uncertainties as nurses made the transition from Staff Nurse to Clinical Nurse Specialist. Nurses found they were not always able to exercise autonomy in the new role because in some instances there was a lack of clarity about the role. Inter-professional conflict and lack of role recognition resulted in one-third of participants in Sullivan-Benz *et al.*'s (2010) well-evidenced Canadian study leaving the nurse practitioner role. In addition, Holt (2008), reporting on community nurses who change roles, notes that when experienced nurses change roles, that shaping of a role involves a balance of role loss and role expansion.

Gaining an understanding of boundaries, its extent and limits, is central to achieving successful transitions for both novice newly qualified nurses and experienced nurses. Boundary conflicts found in this review are most evident when experienced nurses take up new and extended roles (Barton 2007, Glen & Waddington 1998, Griffith 2004, Holt 2008). Conflict features to a lesser extent in newly qualified nurses, but blurring and uncertainty is evident (Boychuck Duchscher & Corwin 2004, Godinez *et al.* 1999, Runganpadiarchy 2006, Schoessler & Waldo 2006). However, conflict, blurring and uncertainty do not feature in pre-registration students' experiences.

### **3.3.6 Theme 3: Learning circumstances**

The analytic theme "Learning circumstances" is independent of "Striving for a new professional self" and "Know-how", but is closely related to both. Concepts in this theme point to facilitators and constraints on work role transitions, including when nurses strive for a new identity and the know-how to competently and confidently perform in their new role. It explains the impact of learning circumstances: support roles; relationships in the workplace; workplace organisation; education and support programmes. Implicit in the findings and following discussion is that when facilitating factors are identified, an absence indicates a corresponding constraint and vice versa. However, constraints and facilitators are explicitly discussed when identified by authors.

#### ***Support roles***

Formal and informal relationships of support were found in the studies of both novice and experienced nurses. The most commonly found formal relationships were mentorship and preceptorship. These terms referred to the individual in the workplace who was formally required to provide learning support for the nurse or aspiring nurse making the transition to a new role. For newly qualified nurses the term "preceptor" was most commonly used. Preceptors were considered vital to facilitate novices' development of their professional self and to acquire the knowledge, skills, competence and confidence required in their new role (Walker 1998, Godinez *et al.* 1999, Gerrish 2000, Boychuck Duchscher 2001, 2008, Ross & Clifford 2002, Newton & McKenna 2007). For all other groups of nurses the term mentor was most commonly used to describe the designated formal learning supporter in the workplace. For pre-registration students they were considered key for development (Fagerberg & Ekman 1998, Swallow *et al.* 2007) and also for nurses studying to move from second to first level registration (Cubit & Lopez 2012) and for applying learning (Melrose & Gordon 2011). Feedback from mentors and preceptors was

needed to facilitate role transition (Boychuck Duchscher 2008, Cubit & Lopez 2012). Experienced nurses also deemed mentors critical in facilitating successful transitions. Holt (2008) found this of hospital nurses moving into community settings, and Sullivan-Benz (2010) of experienced nurses moving to nurse practitioner roles.

Less formal support for learning provided by “colleagues” and “team members” in the workplace was also identified as facilitating transitions. This was found of novice nurses, both newly qualified (Walker 1998, Boychuck Duchscher 2001, Schoessler & Waldo 2006) and pre-registration (Fagerberg & Ekman 1998, Bjorkstrom *et al.* 2006), as well as experienced nurses. Barton (2007) reported that changing relationships with colleagues facilitated transition to nurse practitioner and that role models were needed. Seng and Sanubol (2004) found the support of experienced nurses and team members vital to becoming sexual assault nurses.

Both novice and experienced nurses deemed competence and experience to be important attributes for colleagues, team members, mentors and preceptors to possess (Boychuck Duchscher, 2001, Bjorkstrom *et al.* 2006, Sullivan-Benz *et al.* 2010). Insufficient autonomy (Boychuck Duchscher 2001) and overly vigilant supervision was reported to constrain newly qualified nurses’ transitions (Etheridge 2007). In addition, when expectations of support by preceptors are unmet newly qualified novices feel their development is constrained (Boychuck Duchscher 2008, Deasey *et al.* 2011).

### ***Relationships in the workplace***

The attitudes and behaviours displayed by those who provide formal and informal support can also constrain the transitions of both novice and experienced nurses. Newly qualified nurses report that poor attitudes and behaviours are constraining (Boychuck Duchscher 2001, Roziers *et al.* 2014), as are horizontal violence, bullying and bitchiness (Newton & McKenna 2007, Roziers *et al.* 2014). Problematic relationships in the workplace are reported to constrain by Schoessler and Waldo (2006) and by Boychuck Duchscher (2001). Both of these reporting from North America single out relationships with physicians as particularly problematic, while in the UK Glen and Waddington (1998) report that effective interpersonal relationships with medical staff are important to ease the transition process. Pre-registration students found Enrolled Nurses’ power in the workplace constraining (Fagerberg & Ekman 1998), and students formerly employed as

HCAAs found animosity from other HCAAs in the workplace problematic. Moreover, experienced nurses found resistance from colleagues to role change problematic (Barton 2007, Glen & Waddington 1998) and unrealistic expectations unhelpful (Holt 2008).

Acceptance as a colleague and team member was an important facilitating factor for newly qualified nurses' transitions (Walker 1998, Boychuck Duchscher 2001, Schoessler & Waldo 2006). Pre-registration students also reported that acceptance by team members was important (Bjorkstrom *et al.* 2006, Fagerberg & Ekman 1998), as did experienced nurses (Barton 2007, Holt 2008).

Across geographical locations and quality ratings the formal support structure provided by competent preceptors and mentors has been identified as very important to facilitate nurses' work role transitions. Informal support by the wider team was also found to be important and this review indicates that during the process of transition poor working relationships with colleagues and team members constrains role acquisition. Poor attitudes and values displayed by team members constrains, while acceptance as a team member facilitates transitions for all groups of nurses.

### ***Workplace organisation***

The organisational structures and processes of management in the workplace were found to have an impact on nurses' work role transitions. Workload was an issue found across novice and experienced pathways which could facilitate as well as constrain transitions.

A major factor constraining nurses' transitions was lack of time to develop the new professional self and acquire the know-how to competently and confidently perform in the new role. For newly qualified nurses lack of time (Kapborg & Fischbein 1998, Bjorkstrom *et al.* 2008) through heavy workload (Kapborg & Fischbein 1998, Ross & Clifford 2002, Roziers *et al.* 2014) and low staffing levels (Rungapadiarchy *et al.* 2006, Schoessler & Waldo 2006) was a constraining factor, impacting on support programmes. Novice pre-registration nurses also found lack of time constraining (Bjorkstrom *et al.* 2008), and Fagerberg and Ekman (1998) reported that RNs lacking time to mentor students impacted detrimentally on programmes of support. Experienced nurses also found lack of time constraining. Enrolled Nurses reported that, in extremis, lack of time resulted in them terminating employment to continue with programmes of preparation for

registration (Melrose & Gordon 2011), while Holt (2008) found lack of time constrained RNs moving to community practice.

Conversely, newly qualified nurses reported reduced workload (Boychuck Duchscher 2008, 2009) and supernumerary status (Gerrish 2000, Boychuck Duchscher 2008) important facilitators. Pre-registration nurses reported that a period of substantial rostered practice prior to registration facilitated transition (Deasey *et al.* 2011), while experienced nurses also reported reduced workload to be important (Brown & Olshanksy 1997).

Managers' attitudes and behaviours can be constraining. Rundapadiarchy *et al.* (2006) reported that a blame culture pervaded management, impacting on newly qualified nurses; Walker (1998) bemoaned poor management support, while Boychuck Duchscher (2001, p. 437) reported an "oppressive intellectually restrictive environment". Newly qualified nurses were also constrained by being put into situations beyond their competence (Roziars *et al.* 2014) and being moved between practice areas (Boychuck Duchscher 2008). Roziars *et al.* (2014) also reported seeing unethical practices and feared victimisation.

Experienced nurses reported that workplaces which provided clear role definitions and boundaries aided transitions (Glen & Waddington 1998), but a lack of information about new roles and not acknowledging them was constraining (Barton 2007, Bombard 2010, Sullivan-Benz *et al.* 2010).

Feedback and appraisal were reported to facilitate experienced nurses' transitions (Glen & Waddington 1998, Seng and Sanubol 2004), while lack of feedback can be constraining (Seng & Sanubol 2004, Sullivan-Benz *et al.* 2010). Boychuck Duchscher (2008) also highlights the importance of feedback for newly qualified nurses.

A recognised career pathway was noted as important by Boychuck Duchscher (2008) for newly qualified nurses, while Glen and Waddington (1998) noted its importance for experienced nurses moving to Clinical Nurse Specialist roles. Experienced nurses are also constrained by lack of infrastructure for new roles, including legislation and regulation (Sullivan-Benz *et al.* 2010).

The option to become involved in a variety of workplace activities such as research and be provided with development opportunities was also seen as important to facilitating transitions by newly qualified (*Bjorkstrom et al.* 2008) and experienced (Brown & Olshansky 1997, Glen & Waddington 1998) nurses.

The workplace environment and its learning circumstances including its structures and processes have an important impact on nurses' work role transitions. When inadequate time is structured into the process of work and when heavy workload and inadequate staffing levels exist, these constrain all nurses' transitions, and in particular novice nurses. The lack of supportive managers and poor organisation of the workplace also have detrimental effects. Environments which are ill-prepared to support work role transitions and lacking processes, for example feedback mechanisms, constrain novice and experienced nurses alike.

### ***Education and support programmes***

Programmes of education and support in the workplace were reported as important learning circumstances for facilitating the development of a new professional self and for developing the "know-how" required in a new role. Orientation and induction programmes were found facilitative particularly by novice newly qualified nurses (Kapborg & Fischbein 1998, Walker 1998, Gerrish 2000) and by pre-registration students (Deasey *et al.* 2011) and some experienced nurses (Glen & Waddington 1998).

"Graduate nurse programmes" and "intern" and "residency programmes" were terms used in North American studies to describe a range of formal programmes. These could include induction and orientation to the workplace and some teaching for newly qualified nurses (Boychuck Duchscher 2001, 2008), but Roziers *et al.* (2014) reported that poor staffing levels resulted in abandonment of preceptorship programmes to the detriment of novice nurses. Boychuck Duchscher (2008) reported that short orientation and induction programmes were insufficient to ease transitions. However, orientation programmes were reported to facilitate nurses moving from Enrolled Nurse to RN for experienced nurses in Australia (Cubit & Lopez 2012). Dearnley 2006 reported that learning to be a reflective practitioner also facilitated the transition, increasing professional confidence, autonomy and motivation.



Lack of academic input to transition programmes was found to be constraining in some studies. Boychuck Duscher (2008) reported that withdrawal of faculty support was constraining for newly qualified nurses. Ross and Clifford (2002) reported that newly qualified nurses perceived their educational preparation lacked focus and knowledge and skills for practice. Pre-registration students found lack of access to educators problematic (Deasey *et al.* 2011) and lack of communication between the workplace and academia was reported as problematic by experienced nurses (Bombard *et al.* 2010).

Programmes of induction and orientation provide both the structure and the processes needed to support the work role transitions of newly qualified nurses. The value of these programmes was also found to be facilitative for student nurses, but in this review they were not evident as facilitators for experienced nurses, except for Enrolled Nurses studying to become an RN. The facilitative value of academic programmes in the workplace featured less in this review than induction and orientation programmes with respect to all groups of nurses.

### **3.4 Discussion**

The synthesised findings from this review indicate two pathways through the transition process and three analytic themes. The pathways comprise of novice and experienced nurses and the three analytic themes, “Striving for a professional self”, “Know-how” and “Learning circumstances” are common to both pathways. “Learning circumstances” can facilitate and constrain both pathways through transition but work role transitions are negotiated in somewhat different ways according to pathway.

Common to both pathways, findings indicate that striving for a new identity is an uncomfortable experience. Transition theories from different perspectives – Bridges (1995) from work role, van Gennep ([1090] 1960) from anthropological, and Meleis (2010) from nursing – contend that the experiences of transitions are universal, staged and discomfiting. They involve a generalised sense of disequilibrium for people deep in the throes of change. This is evident in the emotional upheavals nurses experience through all pathways of role change found in this review. Anxiety was experienced as their existing social systems, their workplace and their relationships with colleagues changed. It has long been recognised that these changes provoke heightened anxiety in nurses (Menzies 1960). The transition process is characterised by anxiety and discomfort as

old roles are left behind, new ones not yet fully incorporated, and an in-limbo period of feeling in “no man’s land” is experienced.

An outcome of discomfort and disequilibrium is stress, which includes anxiety and fear. Although present in all nurses’ pathways through transition, it is particularly in evident in newly qualified nurses. Evidence from studies (Brown & Olshansky 1997, Fagerberg & Ekman 1998, Godinez *et al.* 1999, Ross & Clifford 2002, Dearnley 2006, Schoessler & Waldo 2006, Barton 2007, Boychuck Duchscher 2008, Roziers *et al.* 2014) indicate that across time and geographical locations, stress is evident in these novices. Moreover, newly qualified nurses also experience reality shock, which according to Kramer (1974, p. 4) is “the reaction to the discovery that school bred values conflict with work-world values” and “the disparity between the expectations and reality”. Frustration, disappointment and dissatisfaction are experienced as a consequence of newly qualified nurses’ ideals and values being thwarted (Maben *et al.* 2007), including their perceived inability to perform skills competently and confidently. Boychuck Duchsher (2009), building on Kramer’s work, outlines a transition shock theory which includes physical, intellectual, emotional, developmental and socio-cultural change.

Experienced nurses in this review were found not to be subject to this extreme emotional upheaval. In addition, evidence suggests that they may be able to use their prior experience to mitigate stress. Studies reported (Glen & Waddington 1998, Deasey *et al.* 2011, Melrose & Gordon 2011) that prior experience of the work context, alongside utilisation of existing skills, facilitated ease of transitions. For example, Seng and Sanubol (2004) described nurses’ transition to sexual assault nurse more akin to role expansion rather than transition because as experienced nurses they already had pre-existing skills and mechanisms in place to deal with stress associated with the new role.

Striving for a new professional identity is tied to how nurses perceived themselves relative to colleagues: their reference group. Good relationships in the workplace and being accepted were found to be important facilitators of successful transitions for both novice and experienced nurses across geographical locations. Ohlen and Segesten’s (1997) concept analysis of nurses’ professional identity supports this finding, defining identity as comprising two dimensions; personal and interpersonal. Ibarra (1999) adds that professional identity is a constellation of

attributes which includes beliefs, values and motivations. The link between identity, attitudes and values was found in this review to be tied to novice nurses. In contrast, the literature on experienced RNs does not discuss their attitudes and values, perhaps suggesting that desirable attitudes and values of a nurse are assumed by participants and researchers alike to be already embedded in this group. However, a useful reminder is provided by Bombard *et al.* (2010) that transition and a new identity is not always achieved. Bombard and colleagues participated in a programme to prepare them for Clinical Nurse Leader (CLE) roles, but record that they did not experience successful transitions. Perhaps this is not surprising given that they were direct-entry master's students and "non-nurses" with approximately eight months' clinical practice experience prior to starting the CLE programme.

The acquisition of skills to fulfil the demands of new roles is an important step in developing competent practice, as noted in papers on novice nurses (Brown & Olshansky 1997, Bjorkstrom *et al.* 2008, Bombard *et al.* 2010) and experienced nurses (Glen & Waddington 1998, Sullivan-Benz *et al.* 2010). However, some evidence suggests that experienced nurses already have clinical skills in place to meet some demands of new roles (Brown & Olshansky 1997, Seng & Sanubol, 2004). This contrasts with novice nurses, who may not have sufficient skills to draw on to ease their transition (Rundapadiarchy *et al.* 2006). Moreover, communication skills are a concern for novice nurses, although competence increases over time (Bjorkstrom *et al.* 2008). In contrast, the studies of RNs did not report on their communication skills, perhaps suggesting that they are already well developed. This remains an area to be more fully researched since, as Benner (1984) suggests, any nurse entering a clinical situation where they have no experience may be limited to the novice level of performance.

Gaining an understanding of boundaries, their extent and limits, is central to achieving successful transition and a new identity for both novice newly qualified nurses and experienced nurses. Boundary work is closely tied to identity work (Allen 2002) and boundary conflicts found in this review were most evident when experienced nurses took up new and extended roles. Conflicts feature to a lesser extent in the experiences of newly qualified nurses and do not feature in this literature review on pre-registration students' experiences. This suggests that pre-registration students' boundaries are more tightly prescribed than others, due to the highly prescribed frameworks which bound pre-registration programmes. Managers have a role to play in ensuring

that the boundaries of work roles are clear to individuals. Further, Kramer *et al.* (2013) suggest moving from focusing on individuals to work environments and developing them to facilitate successful transitions. It has long been suggested that work role transitions are generally neglected development opportunities not only for individuals but also for organisations (Nicholson & West 1989).

Work role transitions can be facilitated or constrained by learning circumstances in both pathways through transition. Transitions involve personal and professional change and skills development and are inherently discomforting, stressful experiences which create disequilibrium. In a classic study, Menzies (1960) found that high levels of anxiety existed in nurses and the social defence system which operated in the workplace did little to modify and reduce it. Unfortunately, this review indicates that levels of anxiety remain high over half a century later across both novice and experienced nurses' pathways, albeit in a different time and context.

The nursing literature is replete with suggestions for special programmes of support (see Yet Foon Chung *et al.* 2008, Patterson *et al.* 2010), and effective support and mentorship (see Newton & McKenna 2007, Melrose & Gordon 2011) to facilitate good and successful transitions.

The papers in this review indicate that formal and informal support, effective relationships in the workplace and programmes of preparation facilitate transitions. These findings add weight to calls for effective preceptorship/mentorship programmes, which are particularly important for newly qualified nurses, given that they are the single most vulnerable group who experience the extreme form of emotional upheaval, namely shock. However, current fiscal constraints make delivering suitable preparation programmes a challenge for education providers and clinicians alike. Nonetheless, supportive managers and working cultures and practices are important (Kramer *et al.* 2013), including for experienced nurses, despite their having prerequisite skills to ease their transition pathway. However, this review also found that role conflict and boundary issues are of particular importance for newly qualified and experienced nurses who change roles. It also found that a professional identity is formed in relation to reference groups. Allen (2002), in a classic research paper (Rafferty & Traynor, 2002), tracked the effects of significant policy at the local level on the workplace. The study suggested that boundaries and hence the character of professions have to be "accomplished" rather than existing in some natural or stable way. An

understanding of the contingent nature of work role boundaries may facilitate management of the workplace and those in transition. In addition, this review has highlighted that models of transition are available in the existing literature which can facilitate role change. These can support not only the nurses undergoing work role change but also developments in the work environment and in education and all who are involved in nurses' work role transitions.

This review demonstrates disproportionate numbers of studies in each of the pathways. Studies of newly qualified nurses were the largest proportion (44%), nearly twice as many as those on experienced nurses moving to specialist roles (25%). Pre-registration studies account for 22% of the total reviewed. Given that at the time of writing the financial outlay required to educate an adult nurse is £9,143 per annum (Jelfs & duPury 2014), more work on this pathway may be justified on this account alone, quite aside from the potential benefits for individuals. As the Willis Commission (RCN 2012b) asserts, more research into pre-registration nurse education programmes is needed to ensure that programmes are fit for purpose.

### **3.5 Limitations**

No studies from developing nations were found and the decision to exclude cross-sectional studies, of which there are many, meant that additional evidence may have been omitted. The quality of the included studies also influences this review (Appendix 3.4), including the design and methods. On the one hand, case studies may not be generalised (Bowling 2014), and on the other hand, surveys with bigger samples would have been more likely to reflect the populations studied (Field 2009). For example, Deasey *et al.* (2011) suggest that their study numbers were low, limiting their ability to generalise findings and demonstrate causative associations. Moreover, no studies were identified which met the inclusion criteria for nurses moving from clinical to management or academic roles, and this prevents the exploration of the widest scope of role change for experienced nurses.

### **3.6 Conclusion**

This review has informed the aim and objectives of the present study. It has developed a broad understanding of the transitions nurses experience across a wide range of work role changes. This informs the aim of the present study: to understand the transitions of former HCAs when they

become student nurses. In addition, it has informed the objectives of understanding experiences of transition of former HCAs and the impact on them by indicating common characteristics of transitions experienced by novice and experienced nurses. They are universally discomforting experiences for individuals deep in the throes of change. A new professional self and know-how must be developed for change to occur, and learning circumstances can facilitate or constrain the transition.

There are, however, some differences in the ways novice and experienced nurses cope with transition and this also informs the present study. All groups experience stress, although newly qualified nurses experience the most extreme emotional upheaval – shock. There is some evidence that experienced nurses can draw on prior experience to mitigate stress because they have existing clinical and coping skills. However, they are most susceptible to boundary conflict issues when taking up new and extended roles. Successful transitions for both novice and experienced nurses are facilitated and constrained by formal and informal support roles, good and poor working relationships, the management of the workplace and education and training.

The papers in this review, and the literature in Chapter 2, indicate that theories of transition can aid understanding of them. Grand, middle and substantive theories were presented and discussed in Chapter 2. In addition, role theory was discussed in Chapter 2, indicating its usefulness in providing further insights into how the pattern of transition is experienced. Theories of transition have also been presented and discussed in this chapter, in relation to particular groups of people, including novice and experienced nurses. However, it and the literature reviewed in Chapter 2 indicated a paucity of explanation of the transition from HCA to RN. One paper (Brennan & McSherry 2007) presented a model of transition which the authors suggest can be developed. It can also inform the objective of the present study: to develop a model of transition. It can reflect the experiences of this particular group of novices, since, as this review indicates, experiences of transition can be somewhat different for different groups of nurses.

## **Chapter 4 Design and methods**

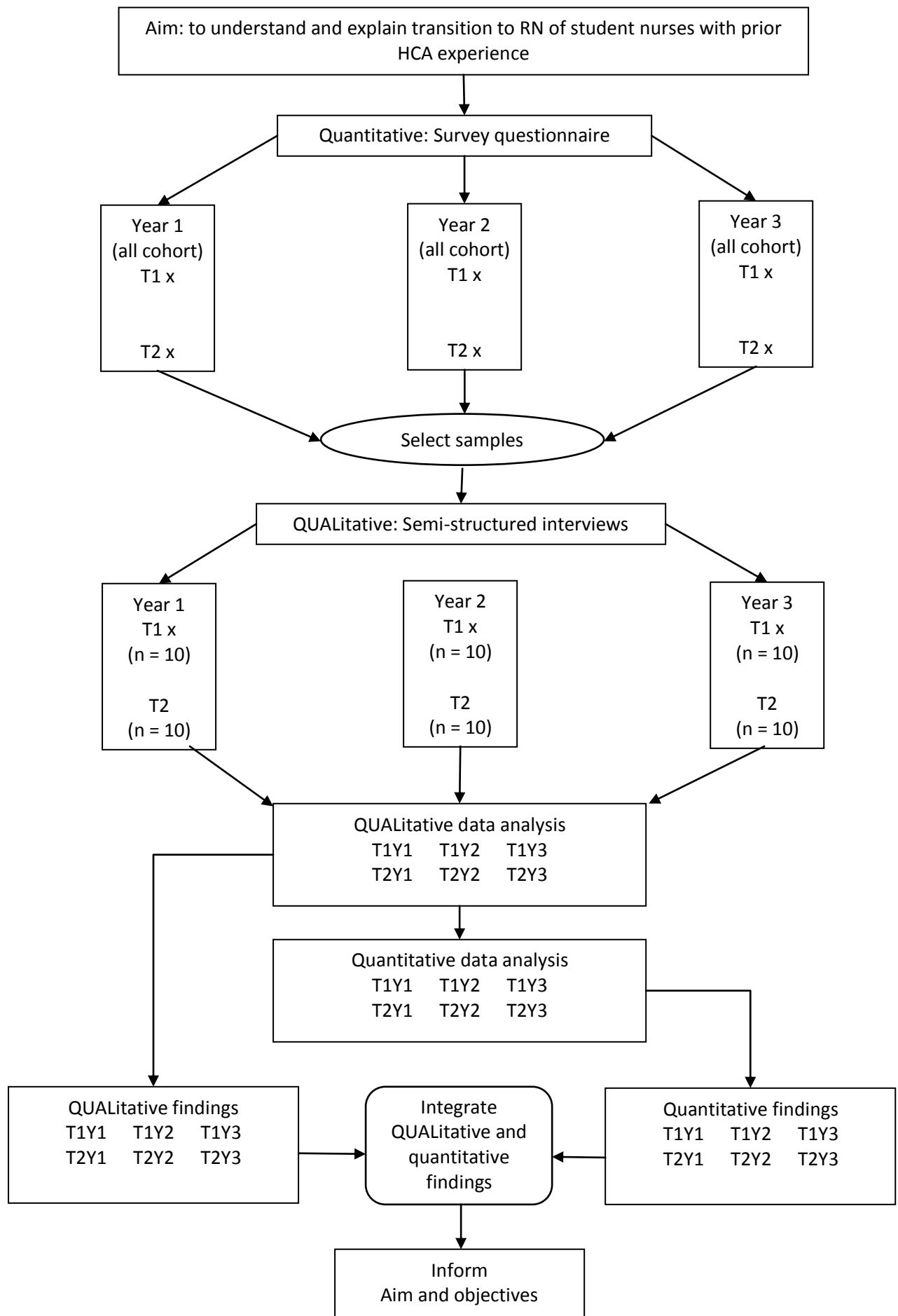
### **4.1 Introduction**

This chapter explains the study design, the methods chosen to collect the data and how the data were analysed and integrated. Section 4.2 provides an overview of the study design, Section 4.3 discusses the research sites and Section 4.4 the samples. In Section 4.5 the development of data collection instruments, questionnaire and interview schedule is presented and Section 4.6 explains the data collection procedures. Ethical considerations are discussed in Section 4.7 and Section 4.8 discusses the strategy for data analysis. Section 4.9 reviews quality and validity strategies and Section 4.10 summarises the chapter.

### **4.2 Design**

To meet the aim of understanding the work role transitions of student nurses formerly employed as HCAs, mixed methods were selected. Mixed methods encompass the process of research including philosophical assumptions, the research aims, design, methods of data collection, analysis, interpretation, integration and reporting structures (Plano Clark *et al.* 2014). In this study qualitative approaches were needed to develop a core understanding of experiences of work role transitions, their impact on students and their facilitators and constraints. Quantitative approaches were used to produce statistical measures that describe changes over time, trends and influences on work role transitions. The theoretical drive for this study was qualitative, presented in upper case (QUAL), and the quantitative complementary component is presented in lower case (quan) in Figure 4.1, which provides an overview of the research design.

**Figure 4.1 Research design**





The paradigm approaches were viewed as complementary, seeking to combine the strengths of qualitative and quantitative methods (Greene 2007) and extend the depth and breadth of understandings and explanations of transitions. To maintain rigour the components were analysed separately up to the point of interface and the core qualitative component formed the foundation for reporting the results (Morse 2010). The sequencing and dominance of qualitative and quantitative strands has, according to Morse (2010), eight possible permutations. In this study the dominant approach was qualitative to capture experiences of transitions and the order sequential, with the qualitative data collection following the quantitative data collection.

Three cross-sectional surveys were conducted and data were collected at two time points (Figure 4.1). The cross-sectional design enabled data to be collected from three different cohorts of students, each at a different stage in studentship (i.e. Year 1 or 2 or 3) and trajectory of change from HCA to RN. A cohort approach was taken and the data were collected and analysed both within each cohort and across cohorts to identify change over time. Under the appropriate circumstances, a longitudinal approach with collection of data from the same group of students from the start of Year 1 to the end of Year 3 could have been considered for this study, but was precluded for a variety of reasons. Although longitudinal studies are considered the most likely to capture change over time, patterns of transition and the activity therein (Wall & Williams 1970, Kralik *et al.* 2006, Brennan & McSherry 2007) and work well with mixed methods studies (Plano Clark *et al.* 2014), attrition is a problem which bedevils them (Parahoo 2014). The cross-sectional approach taken in this present study may have reduced attrition rates through three cohorts participating over one academic year, rather than one cohort over three years. The problem of “cohort effect” is also problematic in longitudinal studies but could not be entirely eliminated in the cross-sectional approach. For example, the impact on any one group of sharing common experiences such as a poor year group leaders and lecturers could have affected, for example, students’ views and experiences of their education. However, this problem may have been reduced by students at two separate universities participating, so having different cohort experiences and the cohort effect having less time to establish. Moreover, longitudinal designs, because of their prolonged nature, may raise awareness of the phenomenon under study and instigate change in attitudes and behaviours over time. The cross-sectional design adopted herein may have been less likely to prompt this effect. Additionally, the limited time frame for PhD studies and limited financial resources of the student researcher also indicated that a cross-

sectional design was appropriate for this study. It allowed for data to be collected over one year ten months, considerably less than the four years two months taken by some of the sample to complete their studies. This would have been the minimum time required for data collection if a longitudinal approach had been adopted. Additionally, the cost of this study was reduced by the researcher personally administering all data collection, aside from the web survey which Lombard University controlled. The interviews were conducted and transcribed by the researcher, again containing costs, but also greatly contributing to developing familiarity with the data.

#### **4.2.1 Data collection methods**

Each of the three cohorts was surveyed by questionnaire at the beginning and end of each academic year, then following each survey a purposive sample of students took part in semi-structured interviews. The time points when data were collected were selected to identify changes students experienced during the academic year (Neale and Flowerdew 2003). The interviews as the dominant element provided a central focus of analytic attention (Thompson *et al.* 2003) and the survey questionnaire was designed to complement interview findings by providing data to statistically measure change and test changes students experienced over time. Semi-structured interviews were chosen because they are well suited to the exploration of individual people's perceptions and opinions of complex and sometimes sensitive issues (Bowling 2014). They can also provide the opportunity to probe for more information and for clarification of answers (Plano Clark *et al.* 2014). For the present study an interview topic guide was developed which identified broad questions and areas of discussion but allowed the researcher freedom to ask additional questions. On the other hand, questionnaires do not generally allow respondents to elaborate, expand, clarify or illustrate their answers (Parahoo 2014). They do however provide the opportunity to collect data from larger numbers of people than the interviews because they are generally less resource intensive (Parahoo 2014). Also, because questionnaires are structured and predetermined, as a rule they cannot be varied in their wording and the order in which they are answered, so have a fair degree of reliability (Field 2008).

The methods were viewed as a set of interactive parts (Tashakkori & Teddlie 2010) where qualitative and quantitative data flow into one another (Creswell *et al.* 2009). The data itself was seen as two modes of representation whereby numbers or text are just two forms of information which can be collected and analysed in a "data-adequate" way, recognising that measurement is

itself a form of interpretation (Biesta 2010). A systematic exploration of the data and the concepts embedded in students' work role transitions produced complementary subsets of results (Bergman 2010). These were compared and contrasted to determine which interpretations of transitions are more and less likely to be valid. The findings go beyond those generated by one method of collection alone to enrich overall findings (Bergman 2010, Tashakkori & Teddlie 2010). By *not* being limited to methods previously considered consistent with qualitative and quantitative approaches to data collection, quality and rigour can be demonstrated through the selection of the most appropriate research tools and using them appropriately to meet the aim and objectives of the study (Richie & Lewis 2003). Combining the two paradigms and using two distinct methods provided two different kinds of data to inform and illuminate (Tashkkori & Teddlie, 2010) the experiences, impact, facilitators and constraints to transition of students with prior HCA experience, as well as models of work role transitions.

### **4.3 Research sites**

Students from two universities, Castleton and Lombard, took part in this study.

#### ***Castleton University***

Student nurses at Castleton studied full time and their academic input was primarily delivered by face-to-face teaching at two campus sites with clinical placements close by. Each site had two intakes, September and February, and the September intakes were selected, being the larger of the two and offering greatest potential for maximising participant numbers. The length of the pre-registration programme was three years and the size of each intake varied across sites and between years.

#### ***Lombard University***

Nursing students at Lombard studied part time and the academic programme spanned four years and two months. Academic input was delivered primarily through distance learning and students were located across England, Scotland, Northern Ireland and the States of Jersey. All students were former HCAs/assistant nurses who were seconded to the programme for 26 hours a week. Clinical learning took place in the students' sponsoring institution and, as with academic learning, was subject to the same requirements as other universities delivering pre-registration nursing programmes approved by the Nursing and Midwifery Council. The clinical area which supported

and seconded students provided the “home” base. Here students were allocated a mentor who oversaw their placement experiences throughout the four years two months of studentship. Students gathered additional clinical experience in a range of placements which contrasted with their home base, supported by local mentors.

Theoretically the entire population of student nurses with prior HCA experience could take part in the present study. However, as discussed in Chapter 1, numbers of students with this experience are not routinely recorded by universities, making access extremely difficult. Instead, a sample were targeted, taking into account how they could be accessed and who could realistically take part (Parahoo 2014). Lombard University nursing students were unique in that all had prior HCA experience. This created the potential to gain access to a large number of students with the prerequisite experience through one institution. Early informal approaches indicated that access was likely to be granted. As noted above, Lombard students studied part time and their academic programme was primarily delivered through distance learning at a large university. This programme did not entirely reflect the experiences of students studying more traditionally. Students at UK universities other than Lombard usually study full time and tuition is primarily delivered face to face. To reflect the experiences of these students a second university, Castleton, was approached. Early informal approaches again indicated that access was likely to be granted. Moreover, as noted above, the students at Lombard University were studying at a large national university while Castleton students studied at a small local university in a more traditional manner. The contrasting nature of the sites selected potentially provided access to a wide range of participants whose experiences of transition were potentially broad and varied. Moreover, the researcher was able to travel to both university central campus sites without unduly large time or financial restrictions.

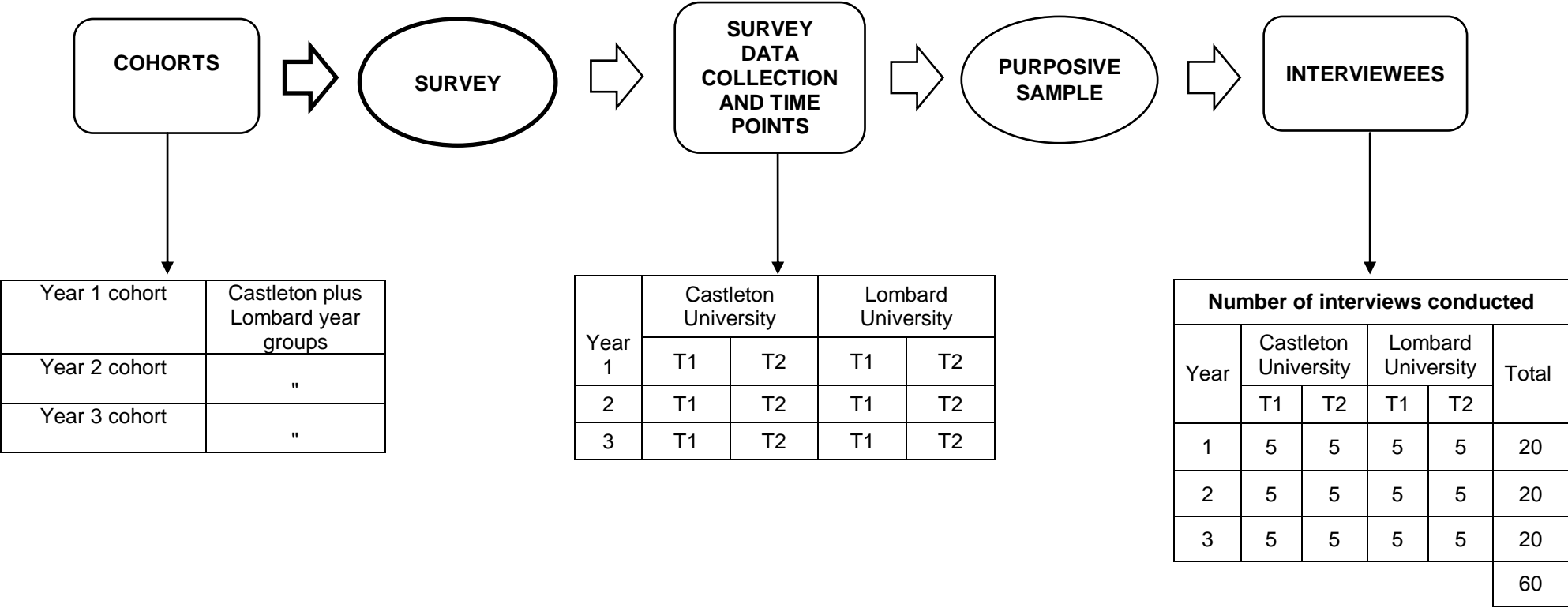
## **4.4 Samples**

Student nurses with a prior HCA experience were the target sample on the basis that they were the best people to provide data on student nurses’ experiences of transition from HCA to Registered Nurse. The sampling was multistage, identifying students to take part at various stages in their studies (Collins 2010). Students studying Year 1, Year 2 or Year 3 of pre-registration nursing programmes comprised the three cohorts who took part in this study. One year group from Castleton University and one year group from Lombard University made up each

cohort sample. All students were studying the adult field of pre-registration nursing programmes, and only those who had worked as an HCA for a minimum of six months before beginning their studies were included. This criterion was imposed because less than six months in the role would not ensure sufficient role exposure to enable comparisons to be made when discussing the transition process (Brennan & McSherry 2007). The decision to include only Adult Branch students was made partly on theoretical and partly pragmatic grounds. Theoretically it is possible that Mental Health, Learning Disabilities and Children's Branch students' learning experiences and their transitions could be different from those of Adult Branch students. Also, given the limited resources of the researcher, accessing Adult Branch students only was more feasible than attempting to access students in all branches.

Students in each cohort were surveyed at the beginning and end of each academic year, Time 1 and Time 2 (T1 and T2). From the cohort a sample of students took part in the survey. From those who took part in the survey a purposive sample took part in interviews (Figure 4.2).

Figure 4.2 Sampling procedure



Students at Castleton University took part in a paper-and-pencil survey by self-completed questionnaire. To maximise the sample all students at Castleton were approached at each time point in person by the researcher who explained the purpose and importance of the study for students. Students at Lombard University were geographically widely dispersed and were invited to take part electronically via email administered through the university student survey office.

From the completed questionnaires potential interviewees were identified. From the questionnaire and through question number 13, students were selected to provide a range of transition experiences and demographic differences. This question asked students to respond to items covering both academic and clinical segments of studentship and was designed to identify potential interviewees and not for statistical testing. Table 4.1 presents question 13 and the scoring system which identified potential interviewees.

**Table 4.1 Selection of students for interview: scoring system**

Q13 How does your former job as an HCA affect you as a student nurse?

	<b>Never</b>	<b>Sometimes</b>	<b>Always</b>
I find it difficult to adjust to being a student nurse in clinical practice	<b>3</b>	<b>2</b>	<b>1</b>
I find it difficult to adjust to being a student in the university/academic setting	<b>3</b>	<b>2</b>	<b>1</b>
I am clear about what is expected of me as a student nurse in clinical practice	<b>1</b>	<b>2</b>	<b>3</b>
I am clear about what is expected of me as a university student	<b>1</b>	<b>2</b>	<b>3</b>
My former job helps me as a student nurse in clinical practice	<b>1</b>	<b>2</b>	<b>3</b>
My former job helps me in my academic studies	<b>1</b>	<b>2</b>	<b>3</b>

High scores indicated high ease with the student role and vice versa, with the highest score possible 18 and the lowest possible 6. Once scores were obtained, one high, one low and three more typical (Teddle & Yu 2007) mid-range scores were used to identify students who had different experiences of transitions. First, students' willingness to be interviewed was checked, and then a range of ages was sought and gender taken into account. Any striking differences were also taken into account including the balance between positive and negative scores on academic and clinical experiences. If there was little to choose between students then the mid-range scores were randomly selected: one of 15, one 14 and one 13. Once identified, students were telephoned using the numbers supplied on the questionnaire, and invited to consider taking part in an interview.

The question of how many interviews to conduct was considered. The National Centre for Research Methods (Baker & Edwards 2012) asked 14 prominent qualitative researchers and five early career researchers to record their thoughts on the issue. The recurring answer was “it all depends”. Common suggestions were to keep epistemological and methodological questions relevant to the individual project in mind and take account of practical issues. In the present study the aim of understanding experiences was kept to the fore and the number of interviews was selected to enable a wide exploration of the different ways in which students experienced transitions and different situations they encountered. Also, the time available to complete the study was carefully considered, including the length of time needed for qualitative interpretative research tasks, difficulties of access and difficulty in transcribing hundreds of hours of interviews. Adler and Adler’s advice (Baker & Edwards 2012) was to conduct interviews within the broad range of 12 to 60, with 30 being the mean. It was decided for this present research that a total of 60 was required. This was at the high end of Adler and Adler’s suggestion to take account of the potential difficulties involved in recruiting more participants in a timely way if analysis indicated more data were needed. Becker (Baker & Edwards 2012) suggested that it takes years of experience to know how many interviews are enough and that it is not possible to know what evidence is needed at the beginning of a project. However, for the present study the one year ten months’ data collection time frame (Table 4.4) did allow time for reflection on the data and preliminary analysis as well as indicating whether further interviews were necessary. It was decided that ten interviews per cohort (five from each university group) would take place at the start of and ten at the end of each academic year. This added up to 20 interviews per cohort and a total of 60 for the three cohorts (Figure 4.2).

## **4.5 Instrumentation**

Survey by self-completed questionnaires and semi-structured interviews following a topic guide were the methods and tools selected to address the research aim and objectives. The same questionnaire was completed by all cohorts and students at both universities at both the beginning and end of the year. Interviews followed the same topic guide between and across cohorts. All data were rendered anonymous and not numbered because the aim was to obtain cohort responses rather than track individuals’ responses or compare universities.



#### 4.5.1 Questionnaire

Questionnaires were selected as the most suitable method for gathering quantitative numerical data from the entire sample given their geographically widely dispersed locations and different modes of programme delivery. The stages of questionnaire development took place between the outset of the study and shortly before its first use in September 2011. The literature was systematically reviewed (see Chapter 3) and the themes “striving for a new professional self”, “know-how” and “learning circumstances” and their codes supported the questionnaire development. Each part of the questionnaire was also linked to the study aim and objectives and all questions contributed towards the attainment of the objective to develop an existing model of transitions. In addition, all parts of the questionnaire were underpinned by the theoretical literature on transitions identified in Chapter 2, in particular van Gennep ([1909] 1960), Nicholson & West (1989), Brennan & McSherry (2007) and Bridges (2009).

Measures of clinical, professional and academic confidence were sought from validated scales to explore experiences of transitions and were subsequently adapted. Confidence measures were chosen because, as Cope *et al.* (2000) suggest, in order to achieve professional incorporation there is a requirement to demonstrate confidence in one’s abilities.

Clinical confidence was measured through questioning how confident students felt in dealing with difficult situations nurses encounter, professional confidence by how confident students felt in upholding the NMC Code, and academic confidence through a tertiary institution academic confidence scale. The quantitative data from the three confidence measures was analysed to include descriptive and inferential statistics. When validated scales were not found, items were grouped into questions according to the themes found in the reviewed literature. Twenty-two questions resulted and Table 4.2 presents how each is linked to the study objectives and to the literature.

**Table 4.2 Questionnaire links to study objectives and the literature**

Question	Objectives	Themes from the literature review (Ch 3)	Additional literature sources
SECTION A: ABOUT YOURSELF  Questions 1–10 (demographic details)	1		Questionnaire construction: McColl <i>et al.</i> 2001
SECTION B: BECOMING A STUDENT NURSE			Segmentation: Friedson 1970, Melia 1987
Question 10: Why do you want to be a registered nurse?	1,2,4	Striving for a new professional self: identity Know-how: boundaries	Newton & McKenna 2007 UNISON 2010 Kessler <i>et al.</i> 2010
Question 11: How do you feel about being on the programme?	1,3,4	Striving for a new professional self: emotional upheaval	Kramer 1974
Question 12: If you had an ideal nurse in mind at the beginning of the programme to what extent have you achieved your ideal?	1	Striving for a new professional self: identity	Goffman 1959
Question 13: How does your former job as an HCA affect you as a student nurse?	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know-how: competence, confidence, boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Kramer 1974 Benner 1984 Spilsbury & Meyer 2004 Gould <i>et al.</i> 2004
Question 14: How confident are you dealing with (difficult situations nurses experience)	1,2	Striving for a new professional self: emotional upheaval Know-how: competence, confidence	Scale adapted from: Pisanti <i>et al.</i> 2008
Question 15: How have your clinical skills changed since the beginning of the programme?	1	Know-how: competence, confidence	Benner 1984
Question 16: Looking back over the programme how often did you experience (re clinical learning environment and supervision)	3,4	Learning circumstances: support roles, workplace relationships, workplace organisation, education	Scale adapted from Saarikowski <i>et al.</i> 2008
Question 17: How confident are you <b>now</b> that you can deal with (aspects of the role of the RN)?	1,2	Striving for a new professional self: identity Know how: competence, confidence, boundaries	Scale adapted from the NMC “Code” 2008 AND Hoyuelos <i>et al.</i> 2010
Question 18/19: Have you continued to work as an HCA? Average hours per month worked?	1,2,3,4	Learning circumstances: time	Gould <i>et al.</i> 2004 Swallow <i>et al.</i> 2007 Southgate & Felstead 2010

Question 20: What is the impact on you of working as an HCA during the programme?	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know how: competence, confidence, boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Kramer 1974 Benner 1984 Spilsbury & Meyer 2004 Goffman 1959 Gould <i>et al.</i> 2004
Question 21: Reasons for working during the programme	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know how: competence, boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Kramer 1974 Benner 1984 Spilsbury & Meyer 2004 Goffman 1959 Gould <i>et al.</i> 2004
SECTION C: YOUR ACADEMIC SKILLS			Segmentation: Friedson 1970 Melia 1987
Question 22: How confident are you about your academic skills?	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know how: competence, confidence, boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Scale adapted from Sander & Sanders 2009
Is there anything else you would like to tell us about being a student nurse who used to be an HCA?	Potential link to all objectives and aim	Striving for a new professional self Know how Learning circumstances	Questionnaire construction: McColl <i>et al.</i> 2001

The questionnaires were adapted very slightly for each university group to reflect each mode of academic programme delivery and related language (Appendices 4.1 and 4.2). For example, students at Lombard University were asked to record the code number of the nursing module they were studying. This was because the cohorts were identified by module being studied rather than by academic month and year when studies began. Each questionnaire was divided into three sections, the first to record demographic data, the second data relating to clinical experiences and the third about academic experiences. The division of student clinical and academic experience reflects the two segments of learning which students negotiate (Friedson 1970, Melia 1987).

### ***Stages of development***

The stages of questionnaire development took place from the outset of the study to shortly before its first use in September 2011. In addition, to enhance reliability, and in line with research by the National Institute for Health Research (McColl *et al.* 2001), care was taken to ensure optimal layout, unambiguous wording and logical sequencing of questions. A specialist statistician experienced in questionnaire construction for nursing/medical students was consulted for expert opinion. A three-point Likert scale, rather than five-point, was adopted for all questions to facilitate ease and accuracy of use and provide a logical middle point (Bjorkstrom *et al.* 2008). It also promoted ease and accuracy in data entry and analysis (Panagiotakos 2009). The questions and scales were structured to facilitate the production of interval-level data suitable for parametric analysis (Jamieson 2004).

Initially, expert validation of the questionnaire scales and items was sought from two nurse teachers who had experience of teaching student nurses with past HCA experience. One was experienced in teaching primarily in traditional face-to-face universities and the other was experienced primarily in teaching by distance learning. This resulted in a number of revisions to the questionnaire, including adjustment of the wording in section A to reflect the part-time nature of the Lombard University programme, and question 22 to reflect the use of “tutorials” rather than “lectures” for this group of students.

### ***Pilot testing***

Before reliability tests were carried out, the questionnaire was administered to a small group of students (n=9) from a second-year cohort at Castleton University who did not take part in the main study, and had a minimum of six months' prior HCA experience. The purpose of this pilot test was to find out about the quality of the questionnaire and its validity: whether questions were understood by all participants in the same way; whether the format was suitable; whether the instructions were clear; and how relevant and adequate the questions were. This can be termed as testing “content validity” and can be assessed by those with knowledge and experience of the topic (Parahoo 2006, p. 304). Students tested the questionnaire in context (McColl *et al.* 2001, Artino *et al.* 2014), in the university setting, using the paper-and-pencil approach. This testing was used for both the web-based and paper-and-pencil approaches to data collection. Lombard University recommended this approach for the web-based survey because they were unable to

facilitate a web-based pilot test. Students were timed as they filled out the questionnaire to test completion time. Following completion a discussion of content took place and it was suggested that the stem questions (questions 19 and 20) were unclear. As a result removal was considered (Artino *et al.* 2014), but this was rejected due to their perceived importance. Subsequently their wording and print type were revised to enhance clarity. All other groups of questions, including their items, were considered clear. In students' opinions the questions covered the main aspects of studentship relevant to their experience.

### ***Preliminary testing for internal consistency***

The consistency of the questionnaire scales was tested for reliability; however, the contribution of each item to a total scale is a major unresolved issue (Panagiotakos, 2009). Low or non-inter-correlated items with high levels of association with investigated outcomes can obtain accurate scale scores (Panagiotakos, 2009). However, in this study all scales in this survey were evaluated for internal consistency by Cronbach's alpha. Total scale scores were only considered acceptable for statistical analysis in scales with Cronbach's alpha  $<0.7$  (Pallant 2010). Individual items within these scales were analysed as descriptive statistics when conceptually linked to thematic findings. For groups of items which were not taken or adapted from validated scales, here Cronbach's alpha  $<0.7$ , total scale scores not calculated. However, individual items could be analysed descriptively, if linked conceptually with thematic findings. One exception to this rule was the scale on "Feelings" (question 11). This decision was made on theoretical grounds. The literature review had indicated that emotional upheaval is a key theme running through a wide range of literature on nurses' work role transitions. Only question 11 in the survey asked students how they felt about being on a programme of preparation for registration. Preliminary testing indicated low reliability on this nine-item scale (Cronbach's alpha  $=0.569$ ). This was an expected outcome since the nine-item scale was conceptually divided into positive and negative feelings of four and five items respectively. It is outside the repertoire of SPSS to factor analyse scale items with limited scoring ranges. Therefore the statistician ran an exploratory factor analysis (EFA) on the ordinal items of question 11 using Mplus version 4.2. It was assumed that there would be some degree of correlation between factors that emerged and therefore Promax, rather than Varimax, rotation which assumes there is no correlation between the factors, was used. The aim of Promax rotation is to obtain the best solution while keeping the between-factors correlation as low as possible. An EFA of question 11 identified two factors with the negative items 1–4 loading

on to the first factor and the positive items 6–9 loading on to the second factor, with a third “Stress” factor represented by a single item (Appendix 4.3).

#### 4.5.2 Interview schedule

A topic guide was developed to provide a framework for semi-structured interviews. It was designed to reflect, clarify and expand on the survey findings to develop understanding of HCA experience on studentship. Its development reflects the stages and principles of the questionnaire development. As with the questionnaire, all topics and questions contributed to the aim of the study to understand students’ transitions, and to the objectives of explaining students’ experiences, exploring the impact of them and identifying/discussing facilitators and constraints as well as contributing to developing a model to explain the transition from HCA to RN. Both the survey and interview guide were based on the literature (see Chapter 3) alongside other relevant publications, as well as being underpinned by the theoretical literature on transitions. In particular this included van Gennep ([1909] 1960), Nicholson and West (1989), Brennan and McSherry (2007) and Bridges 2009, which essentially indicate that transitions involve change over time and ebbs and flows of activity. Table 4.3 presents the topics selected and the relevant literature underpinning them.

**Table 4.3 Topic guide links to objectives and the literature**

<b>Topic</b>	<b>Objectives</b>	<b>Themes from the literature review (Ch3)</b>	<b>Additional literature sources</b>
Topic 1: About you	1,2,4	Striving for a new professional self: identity Know-how: boundaries, competence	Benner [1984] 2001
Topic 2: Perceptions about self	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know-how: competence, boundaries	Benner [1984] 2001 Goffman [1961] 2013 Gould <i>et al.</i> 2004
Topic 3: Feelings about self	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know-how: boundaries	Kramer 1974
Topic 4: Coping	2,3,4	Striving for a new professional self: identity Know-how: boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Gould <i>et al.</i> 2004 Lave & Wenger 1991 Melia 1987 Swallow <i>et al.</i> 2007
Topic 5: Resources	2,3,4	Striving for a new professional self: identity Know-how: boundaries Learning circumstances: support	Gould <i>et al.</i> 2004 Lewin 1947

		roles, workplace relationships, workplace organisation, education	
Topic 6: Perceived roles	1,2	Striving for a new professional self: identity Know-how: boundaries	Goffman [1961] 2013
Topic 7: Summary of change	1,2,3,4	Striving for a new professional self: emotional upheaval, identity Know-how: competence, boundaries Learning circumstances: support roles, workplace relationships, workplace organisation, education	Goffman [1961] 2013 Gould <i>et al.</i> 2004 Kramer 1974 Lewin 1947

Verification of the topic and the questions within them was sought through a process of discussions with nurse teachers and a researcher who had experience teaching student nurses. The interview questions were gradually refined and reduced from an original 20 which formed an “interview guide” to the final seven topics which comprised the topic guide. A range of questions relating to each topic acted as aide-memoires and prompts used to ensure that the direction of conversations remained fluid yet relevant and able to reflect the content of the questionnaire (Appendix 4.4).

### ***Pilot testing***

The topic guide was pilot tested face to face with two students from the second-year cohort at Castleton University and two from Lombard University via telephone. Thereafter these students did not take part in the main study. Castleton students volunteered to be interviewed following pilot testing of the questionnaire. Students from Lombard were identified and initially approached by their tutors. All interviews took place at a time which was convenient to students and were followed by a discussion of content. Feedback was sought on the topic areas, prompts from the individual questions and the conduct of the interview. In students’ opinions the topics covered the areas of significance in their studentship. Comments included that participation provided a good reflective exercise and an opportunity to be listened to. Students also felt the timing, of between 45 minutes and one hour was appropriate and neither too excessive nor too limited to explain their experiences.

## **4.6 Data collection procedures**

Data collection spanned one year and ten months and was fitted around university timetable requirements and practice placement sequencing and constraints (Table 4.4). Data were

collected at two time points, at the beginning and end of the year of each of the three cohorts, that is, years 1, 2 and 3. The surveys preceded the interviews, which were timed to allow students to gain practice placement experience.

**Table 4.4 Data collection time frame**

Year	Month(s)	Castleton University		Lombard University	
		SURVEY	INTERVIEWS	SURVEY	INTERVIEWS
2010	September	Y2 T1 Y3 T1		Y3 T1	
	October			Y1 T1	
	Nov–Dec				
2011	January	Y1 T1	Y2 T1		
	February		Y3 T1		
	March		Y1 T1		Y1 T1
	April			Y2 T1	Y3 T1
	May–July				
	August	Y3 T2	Y3 T2		Y2 T1
	September	Y2 T2 Y1 T1	Y2 T2 Y1 T2		
	October			Y3 T2	
	November				Y3 T2
	December				
2012	January			Y1 T2	
	February				Y1 T2
	March–May				
	June			Y2 T2	
	July				Y2 T2

#### 4.6.1 Questionnaires

Questionnaires were distributed to Lombard students electronically via email. The electronic survey method provided the best opportunity to reach the geographically widely dispersed students (Cantrell & Lupinacci 2007) and was a well-established way of contacting students in this distance learning university. The questionnaires were sent out at a time approved by the university when students were not submitting assignment work or taking examinations, or when routine course and programme evaluations took place. The process was administered by the survey office, supervised by and in close liaison with the researcher. Each stage of the survey from first “going live” to close of survey was reported to the researcher by the survey office. The



Castleton University students were supplied with pencil-and-paper questionnaires as this university could not facilitate a web-based survey. The survey at Castleton University was administered by the researcher and questionnaires completed in the classroom. The timing was agreed between the researcher and the year leader for each cohort. It was timed to be when students were “in class” attending the university and avoiding assessment periods.

The survey response rates are presented in Chapter 5 and a range of strategies was employed to maximise responses (McColl *et al.* 2001, McPeake *et al.* 2014). These included follow-up reminders for the Lombard University students. Students in each year group at each time point were sent a personalised message reminding them of the closure date of the survey, ten days to two weeks prior to its closure (Appendix 4.5). This did not significantly raise the response rates for any group, so all groups were sent a further message explaining the low response rate, requesting participation and extending the close date by two weeks (Appendix 4.6). The saliency of the subject to students plus anonymity and confidentiality were reiterated (McColl *et al.* 2001).

The survey office had this to say with respect to response rates:

It's interesting – you've said a response rate of 'only' 23% but given that I look over a lot of surveys I'd say that's actually quite a respectable rate! We've seen online response rates in general decline over the years, and I know of a lot of projects that don't achieve that high a rate (email correspondence with Lombard University survey office 25 August 2012).

The Castleton University students were approached only once to complete the questionnaire, as requested by year group leaders. However, mid-year flyers were sent to all Castleton groups reminding them of the research and the end-of-year survey. This strategy was also employed with all Lombard students and the flyer distributed electronically (Appendix 4.7).

#### **4.6.2 Interviews**

After completion of questionnaires, follow-up interviews with the purposively selected students were arranged either face to face on campus, or via telephone, whichever the participant preferred. The decision to offer both telephone as well as face-to-face interviews was based on a range of considerations. The practical point of the difficulties inherent in conducting face-to-face interviews with students spread across the countries of the UK was considerable. Not only was the cost and time of travel substantial for both respondents and researcher, but also non-

attendance held significant ramifications of incurring yet more time and financial costs as well as seriously disrupting the sequencing of interviews, which were planned to take place at specific points in studentship.

Other considerations also played their part. In previous decades there have been assumptions that face-to-face interviews rendered better-quality data than telephone interviews (Irvine 2010). A number of studies have been conducted comparing the two modes (Rogers 1976, Johnson 1989, Donovan *et al.* 1997, Novick 2008, Holt 2010, Irvine 2010). In earlier studies, Johnson (1989) and Donovan *et al.* (1997) found that differences attributable to mode occurred when respondents were discussing potentially incriminating topics. For example, they found respondents more likely to admit to substance abuse in face-to-face rather than telephone interviews. However, other and more recent studies have found the two modes comparable and found little difference in the quality of data obtained (Rogers 1976, Novick 2008, Holt 2010, Irvine 2010). The study by Irvine (2010) concluded that telephone interviews should be considered as a preferred alternative to face-to-face interviews.

In this study, as the interviews progressed the telephone mode emerged as the preferred approach by both respondents and researcher. Students at Castleton University were offered each option and five requested face-to-face interviews. Most Lombard University students were asked to take part in telephone interviews due to their geographical locations, though those living locally were also offered the face-to-face option. All opted for the telephone mode.

The telephone option was offered on practical, ideological and methodological considerations. Practically, the option was less costly for both students and researcher in time and money. Students were busy people and the convenience of telephone interviews plus no financial outlay for travel costs was appealing to them. Also, students worked shifts when on placements and attended university settings irregularly, so telephone interviews appreciably facilitated maintaining the interview schedule. The financial cost of the interviews was borne by the researcher and relieved by a payment plan with the telephone line provider which allowed for free calls between 9am and 5pm. Other considerations were also taken into account. Holt (2010, p. 115) suggests that ideologically the telephone can serve as a “technology of self”, another regulatory technique which shapes subjects in particular ways and requiring respondents to provide rational and

individualistic reflections on their behaviours, such as when social workers go into people's homes and ask people questions about their lives. However, in this research the intensity of the surveillance was felt to be reduced by not physically intruding on the respondents' home territories (Holt 2010), be it their dwelling place or university.

Methodologically, the telephone mode of delivery was also considered compatible with both the nature of the participant group and the planned method of analysis. The respondents and researcher alike were felt to have well-developed telephone skills and the telephone was not a source of discomfort (Novick 2008). In the age of telephones, ubiquitous and essential elements of modern life (Ipsos MORI 2014), students and researcher alike found little difficulty in using this familiar medium of communication. Students were very articulate, having no difficulty expressing themselves, even on sensitive matters. On occasion they moved me, the researcher, to tears, as when a student explained that her Dad had expressed happiness and pride on the day she received confirmation of acceptance into a pre-registration nursing programme, and then he died later the same day. Moreover, the lack of non-verbal cues did not appear to inhibit the conversations and for the researcher it focused her concentration and intensified listening (Irvine 2010), and this in turn aided the substance and flow of the interaction.

In addition, methodologically the telephone was compatible with the planned mode of analysis, providing good quality recordings which when transcribed lent themselves to framework analysis. The technical equipment used was an Olympus digital voice recorder (VN-3100/VN3100PC) plus a telephone adapter for use between the telephone and handset, enabling digital recording. In addition, the Olympus Digital Voice player and the DSS player software enabled audio recordings to be downloaded on to a laptop computer for listening and transcription.

The conduct of the interviews, both telephone and face to face, was carefully considered. All students were first approached by telephone or email and asked if they would consent to an interview. From this initial contact it was important to establish trust and respect between respondent and interviewer. Reflexivity was extremely important (Hammersley 1992) on the part of the researcher and power differences were acknowledged and attended to in a variety of ways. These included: students setting the time, date and location of the interview; the researcher acknowledging to students she was a mendicant and asking for help as a fellow student to

conduct the research; discussion of the meaning of anonymity between student and researcher. In addition, although the researcher could not afford to pay students for their time in taking part in the research, as a reciprocal act students were offered letters outlining their part in the study for inclusion in their pre-registration portfolios (Appendix 4.8). A reduction in the perceived hierarchy between the researcher, a former nurse teacher, and student was the goal (DiCicco-Bloom *et al.* 2006). This approach also aimed to promote the capacity of the researcher to remain objective, arguably compromised by her nurse teacher status. However, this same background also provided an understanding of the structures, processes and language involved in nurse education, and facilitated ease of communication between researcher and respondents. To promote equality further it was explained to students that the interviewer was a student endeavouring to learn and listen and that they were the experts on being a student nurse. Of the 62 students approached for interview, two declined to take part, and several commented that they felt it an important area of research.

The interview itself was timed and shaped to promote respect and reciprocity. As noted above, the timing and mode of the interview were always dictated by the respondent. Moreover, the interviewer recapped and sought affirmation of her understanding after each topic area was discussed. Students were encouraged to correct miscomprehensions. The interview was structured to last approximately 45 minutes to one hour, with the first topic broad and open to provide context and establish reciprocity (DiCicco-Bloom *et al.* 2006). Probing techniques were employed, such as the silent probe, allowing students time to think, echoing what students said and the “Uh-huh” technique, encouraging students to continue with their account. The questions were ladderred (Price 2002) from less to more invasive and centred on thoughts, feelings and actions around the identified themes. These approaches encouraged the researcher not to become engaged in the creation of a joint narrative (Price 2002). In addition, a reflective journal was written as soon as possible after each interview, aiming to provide further insights into the content and conduct of the interviews. This aided the development of researcher skills as well assisting in the administration of the survey. Moreover, critical reflections trigger learning (Mezirow 1991), and in this study they supported data analysis through the recording of embryonic ideas.

## 4.7 Ethical considerations

To undertake this research, ethical approval was first sought from King's College London, then from the two universities where students who took part in the study were located. Following submission of 18 copies of the application, ethical approval was first obtained from King's College for three years' duration (see Appendix 4.9). Access to students at Castleton University was gained through informal approval from Castleton University campus site Directors. Subsequently the Director of the Health Services Institute gave formal ethical approval following review of the formal approval from Kings College London. (Appendix 4.10). At Lombard University approval of access to students was first gained informally from the Director of Nursing. Subsequently, the chair of the Lombard University ethics committee was approached and advised that formal ethical approval, in addition to that granted by King's College London, was required from the Lombard University Student Research Project Panel. This approval was also gained (Appendix 4.11).

The Data Protection Act (1995) and "The Code" of professional conduct for nurses (2008) were adhered to throughout the study. Key ethical considerations that underpinned the research were the commitment on the part of the researcher to promote good (beneficence) and prevent harm (non-maleficence) (Beauchamp & Childress 1994). This included, for example, not approaching students at critical points in their studies such as examinations and other assessments. Students' autonomy was considered of paramount importance, as detailed above (Section 4.6.2), in how the interviews were approached, structured and conducted. The voluntary nature of participation was emphasised, and informed consent deemed an imperative (Tschudin 1993). For interviews students supplied written consent on the day of the interview or for telephone interviews mailed it to the researcher before the interview. For the survey consent was considered to be given when students either submitted the web-based questionnaire or handed over the paper-based questionnaire to the researcher.

Students received an information sheet before participating in the survey and a minimum of two weeks was given for students to consider this information again before being interviewed (Appendix 4.12). The information sheet was sent electronically to students at Lombard University. If students at Castleton had not kept their copy when they completed the questionnaire they were emailed another or mailed a hard copy. The information sheet explained in detail the purpose, structure and conditions of the study, including acknowledging that at the time the researcher was

a nurse teacher at one of the participating universities. However, the researcher had no personal knowledge of the participating students. None the less assurances were given that there would be no impact on students' progression, whatever academic institution they attended, and that any information they gave would be confidential and rendered anonymous. This right to privacy was carefully considered and appropriate actions taken. This included the development of coding and data management systems that would ensure confidentiality and protect the freely given data from misuse (Parahoo 2014).

## **4.8 Data analysis strategy**

### **4.8.1 Student survey**

#### ***Record keeping***

A log book was kept to record changes to the data set and derivation of new variables and to keep track of all analyses and statistical tests performed.

#### ***Data inputting, checking and cleaning***

Data from the web-based survey completed by students at Lombard University was not directly inputted but instead was saved as a Microsoft Excel worksheet and subsequently imported into SPSS v21 by the university survey administrators. However the data from the pencil-and-paper survey at Castleton University was inputted into SPSS v21 directly from the questionnaires by the researcher. Care was taken to ensure that the each question and item was directly related to the questions and items in the web-based survey. The SPSS data from the pencil-and-paper survey was rechecked for error against questionnaires and screened for errors and values outside the range of possible values. It was also rechecked to ensure consistency with the Lombard University questions and items. The web-based survey data were also reviewed. Small inputting errors were found in the Castleton data and were rectified. The files from the two universities were then combined to create one data set. This was because the aim of the research was to understand the work role transitions of a wide range of students formerly employed as HCAs rather than to compare the experiences of students from two different universities.

As data were inputted, for the open-ended section of questions 10 and 11 and for the final question "Is there anything else you would like to tell us....", <20% of the sample responded to these questions. This response rate was considered insufficient was not analysed.

### ***Scale and items scoring***

As noted in Section 4.5, all scales in this survey were evaluated for internal consistency by using Cronbach's alpha. For groups of items which were not taken or adapted from validated scales where Cronbach's alpha scale scores  $<0.7$  the total scale scores were not calculated.

All scales and groups of questions were scored on symmetrical three-point Likert scales scoring 1–3 with 2 assumed as the middle value. Scale items were reversed where necessary to ensure that high scores reflected high levels of outcome measures. For example, in question 15 the outcome aimed to measure changes in clinical skills. Item 3 in this scale "I have lost some clinical skills" scale score was reversed so the "Agree" became a low score of 1 rather than a high score of 3.

### ***Statistical techniques***

Means, standard deviations and frequencies (percentages were rounded to the nearest whole number) were used to describe the variables found in Section A of the survey "About yourself" (which mirrored the first section of the Topic guide "About you") and formed the basis of understanding the background and experience of the entire sample. The variables described statistically were gender, age, first language, educational qualifications, clinical areas worked in as an HCA, main client group worked with as an HCA, years worked as an HCA, branch studied as a student nurse and year of study as a student nurse. This statistical information which follows has been presented in tables and figures for clarity. Statistical computation was performed using SPSS, version 21.

### ***The General Linear Model***

A General Linear Model (GLM) was fitted to the data using the SPSS procedure UNIANOVA to enable the statistical comparison of the six groups in the three cohorts surveyed. All measurements were assumed to be independent and it was taken that clustering effects could be ignored (this aspect is discussed in more detail in the limitations discussed in Chapter 7). The model output from UNIANOVA provided inferential statistics to understand change over time and influences on transitions and included descriptive statistics, homogeneity tests, F-tests, parameter estimates and residual plots. Levene's test for equality of variance was conducted on each GLM

to ascertain whether there was equality of variance across groups since the F-test requires this assumption to be met. The distribution of scores was assessed for normality using descriptive statistics, skewness and kurtosis results alongside QQ plots where each individual score is plotted against its expected value from the normal distribution. For categorical independent variables the null hypothesis ( $H_0$ ) was stated as follows:

$H_0$ : Group means are the same ( $G_1 = G_2 = G \dots = G_n$  where  $n$  is the number of groups)

$H_1$ : Group means are different ( $G_1 \neq G_2 \neq \dots \neq G_n$ )

And for continuous independent variables:

$H_0$ : There is no linear relationship between the independent and dependent variable ( $\beta=0$ )

In the GLM the null hypothesis is tested by calculating the F-ratio for each effect. These F-ratios are presented in the SPSS output in a table under the heading of “Tests of Between-Subjects Effects”. If the F-ratio was statistically significant at the 5% level then further testing of paired groups was undertaken (e.g. six groups lead to 15 pair-wise comparisons), correcting the probability ( $P$ ) for multiple comparisons using the Bonferroni method. Parameter estimates were used to establish whether the relationship between independent and dependent variables was positive or negative. For categorical variables such as cohort group the parameter estimates helped to determine which groups had higher or lower scores, having accounted for variation due to the other independent variables included in the model. Variables with the strongest association with the dependent variable in the GLM were identified using the partial eta squared ( $\eta^2$ ) statistic. Partial eta squared is a measure of the proportion of variance in the dependent variable that is explained by the independent variable (Pallant 2010). To interpret the strength of  $\eta^2$ , guidelines by Cohen (1988, p. 22) were followed: 0.01 (1%) = small; 0.06 (6%) = medium; 0.138 (13.8%) = large. The independent variables used in the GLM to explain variation in clinical, professional and academic confidence total scale scores were as follows:

- 1 Years worked as an HCA split into four groups: <1.5; 1.5–9; 10–19; 20+
- 2 Former workplace split into three groups: hospital; community; both hospital and community



- 3 Hours continuing to work as an HCA split into five groups: <15; 15–30; 31–45; 46–50; 51+
- 4 Positive feelings (score treated as a continuous variable)
- 5 Negative feelings (score treated as a continuous variable)
- 6 Stress (a single measure based on a single item)

In addition, to ascertain whether confidence (clinical, professional and academic) was associated with the clinical learning environment (CLE), a GLM was fitted to each cohort and time point of data collection separately using the methods described above, with the CLE used as an independent variable. An F-ratio and probability value was calculated to find out if this association was due to chance. Levene's test for homogeneity of variance was performed with the confidence measures as dependent variables. GLM tests were performed separately for each dependent variable (clinical, professional and academic confidence), with the CLE as the dependent variable in each case. In Table 4.5 the analyses are listed alongside each survey question. Where there were concerns about the distribution of the GLM residual (difference between the observed value and the value predicted by the model), bootstrap analyses were performed. Bootstrap was performed on 1,000 samples with replacement from the respondent variable.

**Table 4.5 Summary of statistical data analysis and tests**

<b>Questionnaire: From Health Care Assistant to Registered Nurse.</b>	<b>Study objectives</b>	<b>Statistical techniques</b>	<b>Aim</b>
SECTION A: ABOUT YOURSELF  Questions 1–10	1	Descriptive statistics: numbers, percentages, means and standard deviation	Summarise participants' demographic details
SECTION B: BECOMING A STUDENT NURSE			
Question 10: Why do you want to be a registered nurse?	1,2,4	Descriptive statistics: numbers and percentages, ranking	Rank items combining all groups' data
Question 11: How do you feel about being on the programme?	1,3,4	Descriptive statistics  Inferential statistics: GLM	Compare responses across year groups. Assess the influence of feelings (independent variable ) on clinical, professional and

			academic confidence (dependent variables)
Question 12: If you had an ideal nurse in mind at the beginning of the programme to what extent have you achieved your ideal?	1	Descriptive statistics: numbers and percentages	Compare responses across year groups
Question 13: How does your former job as an HCA affect you as a student nurse?	1,2,3,4	Individual scores	Identify students for interviews
Question 14: How confident are you dealing with (difficult situations nurses experience)	1,2	Descriptive statistics: boxplots  Inferential statistics: GLM	Assess and summarise clinical confidence changes as an indicator of transition (independent variable). Compare with professional and academic confidence (dependent variables)
Question 15: How have your clinical skills changed since the beginning of the programme?	1	Descriptive statistics: numbers and percentages	Assess and summarise clinical skills changes
Question 16: Looking back over the programme how often did you experience (re clinical learning environment and supervision)	3,4	Inferential statistics: GLM	Assess the influence of the learning environment (independent variable) on clinical, professional and academic confidence (dependent variables)
Question 17: How confident are you <b>now</b> that you can deal with (aspects of the role of the RN)	1,2	Descriptive statistics: boxplots  Inferential statistics: GLM	Assess and summarise professional confidence changes as an indicator of transition  Compare (as an independent variable) with clinical and academic confidence (dependent variables)
Question 18/19: Have you continued to work as an HCA? Average hours per month worked?	1,2,3,4	Descriptive statistics: numbers and percentages  Inferential statistics:	Summarise and examine hours worked, and  Assess the

		GLM	influence ( as an independent variable) on clinical, professional, and academic confidence (dependent variables)
Question 20: What is the impact on you of working as an HCA during the programme?	1,2,3,4	Descriptive statistics: numbers and percentages	Summarise and examine for similarities and difference
Question 21: Reasons for working during the programme	1,2,3,4	Descriptive statistics: numbers and percentages	Summarise and examine for similarities and difference
SECTION C: YOUR ACADEMIC SKILLS			
Question 22: How confident are you about your academic skills?	1,2,3,4	Descriptive statistics: boxplot  Inferential statistics: GLM	Assess and summarise academic confidence changes as an indicator of transition  Compare (as an independent variable) with clinical and professional confidence change (dependent variables)
Is there anything else you would like to tell us about being a student nurse who used to be an HCA?			

#### 4.8.2 Interviews

As noted above (Section 4.5.2), pilot interviews took place and each was transcribed and scrutinised for fit with the aim and objectives of the study. On review these were evident and for one of the pilot interviews a process of drawing out themes was initiated. The themes were then plotted onto a preliminary “Framework” analysis sheet to explore the use of the “Framework” strategy for the main study (Richie & Lewis 2003). Early indications suggested this would indeed be a workable approach. Moreover, the interviews were also the source of reflection for the researcher to help develop her interview techniques.

The analysis and synthesis of the interview data collected from the main study adopts a broadly thematic approach. Thematic analysis can be used across a range of theories and epistemologies from essentialist to constructionist (Braun & Clarke 2006), but is flexible and can yield rich, detailed and complex accounts (Spencer *et al.* 2003). For this study “Framework synthesis”, which takes a broadly thematic approach, was selected as the approach for analysing and synthesising the interview data. The Framework approach provides a flexible system for managing data in a logical and transparent manner while searching across the data set to find repeated patterns of meaning. It is a systematic approach which enables the development of an account which is as truthful and accurate as possible, and is able to account for the whole of a large data set through development of matrices (Richie *et al.* 2003). This was a considerable advantage for this study, which involved a large and complex data set. Moreover, “Framework” is an inductive approach which demonstrates how themes are linked to the data without trying to fit into any pre-existing code frame or analytic preconceptions (Richie *et al.* 2003). It allowed for a fluid approach to data collection and analysis while mirroring the questionnaire content and provided the opportunity to enlarge on findings. It also provided data to compare and contrast with the findings from the more structured questionnaire (Richie *et al.* 2003). However, it must be acknowledged that this researcher does not exist in a vacuum and the decision to use this approach is itself a theoretical and epistemological decision.

The first step in the analysis began at the start of data collection. Reflections on the conduct of the interview were recorded and where appropriate influenced the conduct of the interviews. Following recording each interview was replayed, interesting elements were noted, patterns of interest recorded and the researcher’s thinking and interpretations written up. In essence this approach underpinned the entire analysis. The following account is an attempt to impose order for the reader on what was an iterative, messy and protracted process. It involved movement back and forth between the data set and the interpretations of the researcher, who was looking for patterns, meaning and ever more nuanced understandings throughout the entire exercise, including during writing the findings and discussion.

As noted above (Figure 4.2), 20 students per cohort were selected for interview making a total of 60 across the three cohorts who were surveyed. To begin the analysis 36 out of 60 recordings were transcribed. In each cohort and at each time point, one high, one medium (middle of the

range) and one low score were selected for transcription. This added up to 12 per cohort and 36 across the data set (Table 4.6). This was in excess of the mean number of 30 interviews recommended by Adler and Adler in Baker & Edwards (2012).

**Table 4.6 Numbers of interviews initially selected for transcription and analysis**

<b>Cohort</b>	<b>Castleton University</b>	<b>Lombard University</b>	<b>Total</b>
Year 1 Time 1	3	3	6
Year 1 Time 2	3	3	6
Year 2 Time 1	3	3	6
Year 2 Time 2	3	3	6
Year 3 Time 1	3	3	6
Year 3 Time 2	3	3	6
<b>Grand total</b>			36

Following transcription the aim was to identify themes from the interviews using the “Framework” approach discussed above. The themes were then checked against the remaining 24 recordings (out of the total of 60), to find out if they were also evident in these remaining recordings, as well as to check for contradictory or new themes. As Becker noted in the NCRM paper (Baker & Edwards 2012), researchers cannot know at the beginning of the process what evidence is needed. To counter this, in the present study the design intention was that if new themes or subthemes were found in the recordings not transcribed, these interviews would be fully transcribed and analysed and, if necessary, further interviews conducted until no new themes emerged.

The initial 36 interviews which were selected for transcription were fully transcribed verbatim by the researcher and checked against the digital audio recording. This enabled not only familiarisation with the contents but also immersion in them. The transcripts were first downloaded and printed, read then re-read, and key words and phrases underlined and notes made in the margins (Appendix 4.13). Next, A3 sheets of paper were used to record tentative ideas concerning common key elements and patterns in year groups (Appendix 4.14). These sheets of paper were methodically spread out across a workroom for a number of weeks as the researcher

read, re-read and thought through them, and checked the notes against the interview transcripts. Next the process of transferring each transcript into the electronic data management system, Nvivo10, began. This was a time-consuming and sometimes frustrating process as the researcher learned to use the system. However, all transcripts were systematically stored in Nvivo "Sources" in folders labelled for each cohort and time point when data were collected. This attention to detail greatly benefited subsequent analyses, enabling easy access to transcripts. Next work started on labelling and tagging the transcripts using an index which was created from the large sheets of paper spread across the workroom. The index comprised a series of "nodes," and each node represented a category taken from the tentative ideas previously recorded. Each node was linked to large chunks of transcript data of several sentences and more, in order to retain context and enable cross-coding into alternative nodes, a process greatly facilitated by use of Nvivo. However, this stage in the analysis did not mark a complete move away from paper-and-pencil analysis.

As the analysis developed yet more large sheets of paper were used to "get a handle" on the large amount of data which had been transcribed, move it around and, crucially, maintain an overview of developing themes. This stage of the analysis provided a visual construction and comprehensive overview of the changing and developing analysis across the three cohorts and the two points of data collection for each (if also providing a somewhat usual room décor). A table was constructed, adapted from Smith & Firth (2011), linking a quotation to a code, and recording thoughts on meaning and some initial categories (Appendix 4.15). Next the categories were developed using a pencil-and-paper chart (Appendix 4.16). The categories were refined and some emerging themes recorded with constant recourse to the verbatim quotes stored in Nvivo. Then the refined categories and emerging themes were transferred to Nvivo nodes. At this point the ease of electronic access to transcripts and previous labelling and tagging was invaluable, enabling the researcher to establish and refine the codes and link them to the emerging themes (nodes) while staying close to the transcripts and verbatim quotations. As the coding work progressed, a review of the categories and the initial themes took place. The categories were revised and developed to add substance, discreteness and meaning to each. At this point ten categories could be found in the data which could be used to create a Framework chart (Appendix 4.17). At the same time theoretical perspectives on the meaning of the data categories were starting to be recorded and charted (Appendix 4.18). The culmination was a "Central chart" typed up to give an overview of the emerging analysis, and listing five themes with subthemes each

derived from the ten refined categories (Appendix 4.19). The themes became the substance of the Framework charts which were drawn up as tables in Microsoft Word 2007. Verbatim quotes were copied and pasted from Nvivo into the Framework chart cells linking the data to the theme and subthemes and to each time and year group (see Appendices 4.20, 4.21 and 4.22) and to the study aim and objectives. It was then possible to compare the charts to identify similarities and differences across the year groups. This prompted the start of writing up the findings. It was during this process that the final themes and subthemes became clearer with constant recourse to the Framework chart and the quotations stored in Nvivo stored under the relevant nodes.

The process of writing was also an iterative and analytic process. It resulted in multiple versions with the theme “Stepping up” being collapsed into others because it lacked individual discreteness. Its content was re-coded in Nvivo to the remaining five themes. Further refinement of the themes and subthemes continued as the integration of theoretical thinking into the writing process unfolded. It was at this point that the entire Framework chart was systematically read and important sections and quotations re-read. Moreover, the interviews which had not been transcribed were listened to for a second time. The recordings were used to check whether the themes which had been identified were also evident in these recordings as well as to check for contradictory or new themes. These alternatives were not found and at this point data saturation was reached (Brannen 2012, Parahoo 2014). However, an emphasis in one subtheme was found to be inconsistent with the analysis. In the subtheme “Transferability” within the theme “The practice milieu” it was clear that students believed their prior experience was helpful. However, the analysis at this point did not give sufficient emphasis to this finding, instead focusing on how prior experience may not help transition processes. The findings were subsequently revised to include the view, evident across the whole data set, that prior experience can be helpful. As each theme, including subthemes, was written up verbatim quotes were sought in Nvivo and checked against the original transcript to ensure that contexts and meanings were substantiated. The quotations chosen were those which expressed the essence of each theme and subtheme and which provided a range of responses across year groups, universities and demographics.

#### **4.8.3 Mixed methods integration**

There is no widely accepted technique or set of ideas for integrating the different types of data in mixed methods studies (Onwuegbuzie & Combs 2010); strategies for integration are needed

(Fitzpatrick 2014) and currently remain underdeveloped (McManamy *et al.* 2015). However, in the present study the qualitative interview data and the quantitative survey data were analysed separately as outlined above. The themes which emerged from the qualitative analysis provided the mechanism to merge the quantitative results and synthesise the findings from both data sets. A thread approach was taken (Moran-Ellis 2006). Both data sets were conceptually positioned alongside each other, and themes identified in the qualitative data, based on the literature and the study aims and objectives, were followed across (the thread) to the quantitative data. This was a focused inductive approach and allowed an inductive lead to the analysis, preserving the value of the open exploratory qualitative enquiry but incorporating the focus and specificity of the quantitative data (Moran-Ellis 2006).

The quantitative data analysis provided descriptive/inferential statistics for the variables indicating change over the three cohorts and two time points when the data were collected. The themes derived from interviews provided a core understanding of students' experiences and this was the dominant strand. The results of this study are presented theme by theme, with both the quantitative and quantitative data presented in each theme, thus a "weaving" approach (Moran-Ellis 2006), and followed by a summary integrating the results further (Chapters 5 and 6). At the point of theoretical interpretation (Chapter 7) integration is continued, and convergence and divergence are discussed (Onwuegbuzie & Combs 2010) and meta-inferences and overall interpretations drawn (Plano Clark *et al.* 2014).

## **4.9 Ensuring quality**

There is no single accepted framework for appraising the quality of mixed methods research (Leech *et al.* 2010, O'Cathain 2010, Ivankova 2014) and opinion varies on what constitutes quality in qualitative, quantitative and mixed methods studies (Bryman *et al.* 2008). A quality framework for mixed methods research was proposed by O'Cathain (2010) combining the quality assessment frameworks published by scholars in the field of mixed methods. This framework and the practical strategies proposed by Ivankova (2014), which refer specifically to sequential quantitative → qualitative studies, have been used to present how the quality and validity of this mixed methods study was secured. A three-step process was followed with separate procedures used to assess the reliability and validity of the quantitative data and the credibility and trustworthiness of the qualitative findings (Ivankova 2014). The strategies for promoting reliability



and validity of the quantitative data are discussed in detail above in Section 4.5 and strategies for ensuring the credibility and trustworthiness of the qualitative data in Sections 4.5 and 4.8 and are briefly outlined again below. Furthermore, overarching strategies were used to ensure the quality and validity of the mixed methods design with its integrated conclusions and meta-inferences. These strategies relate to the “undertaking” and “interpreting” stages of the study including ensuring data quality, interpretative rigour and inference transferability (O’Cathain 2010, pp. 542-543) and are discussed below. First, summaries of the qualitative and quantitative quality strategies are presented.

#### **4.9.1 Validity and reliability of the quantitative data and results**

Validity is concerned with the accuracy with which the findings reflect the transitional processes experienced by former HCAs. Reliability refers to the degree of consistency with which the survey instrument would produce the same results if administered in the same circumstances (Parahoo 2014). The strategies for promoting reliability and validity included developing the questionnaire basing it on the literature reviewed and where possible validated scales in the published literature. Content validity was established through an expert panel of nursing lecturers and a nursing/medical statistician. This was followed by pilot testing of the instrument by nursing students. In addition, Cronbach’s alpha values were used to estimate the internal consistency and reliability of the survey scales and items (Pallant 2010).

#### **4.9.2 Credibility, transferability and dependability of the qualitative data findings**

Credibility, transferability and dependability, according to Koch (2006), can demonstrate quality in qualitative data. To establish the trustworthiness of these criteria Koch drew on the work of Guba and Lincoln (1989), and each of the criteria is now discussed in relation to the present study.

Credibility is established when a study presents faithful descriptions and when the reader recognises the description (Guba & Lincoln 1989). Further, the researcher should make clear how each theme was derived from the descriptions and this can be done by returning to the original text to ensure the conclusions are firmly grounded in the data. Self-awareness is also needed (Koch 2006). In the present study diaries were maintained to aid reflexivity (Rolfe & Freshwater 2001, Walker *et al.* 2013) but also to provide an ongoing record of the complex study design. Several diaries were kept: a daily notebook recording events such as items “to do”; a data

collection diary; a logbook of quantitative analyses and tests; a personal journal recording thoughts and feelings. The data collection diary, although not recorded daily, was particularly helpful in developing self-awareness and critical awareness as thoughts on the developing data set were recorded and reviewed alongside the processes undertaken. This was important in the present study because the researcher could be regarded as lacking objectivity when undertaking and reporting the research (see Section 4.8.2).

Credibility was also enhanced by seeking out similarities and differences in the findings (Koch 2006) and this was supported by the “Framework” approach which enhances transparency of findings (Richie & Lewis 2003). In addition, verbatim quotes are used extensively throughout the “Findings” chapters below to demonstrate the link between theme and data. In Section 4.8.2 above the thoughts in developing the themes have been presented and transparency promoted in discussions and as evidenced in appendices 4.13–4.22. Also, the researcher discussed findings and analyses with three expert researchers and with fellow students and teachers for consensual validation. Data triangulation to promote credibility (Koch 2006) was aided by the mixed methods approach, described above and as discussed in detail in the following chapters.

Transferability, according to Guba & Lincoln (1989), is dependent on the degree of similarity between two contexts. The original context must be described adequately so that a judgement of transferability can be made. In the present study students from two universities participated in the study to seek out commonalities, differences and a range of transition experiences. The study sites and samples are described above (Sections 4.3 and 4.4) and further description of each follows in the findings (Chapters 5 and 6). The aim was to provide sufficient contextual information for the reader to decide if they can make similar judgements which fit into contexts outside this study.

Dependability of research can be audited, just as financial accounts can be audited (Koch 2006). By examining the process by which accounts are kept an auditor can exclude error or fraud and determine accuracy by checking entries in the ledger. In the same way a research decision trail provides a means to establish an audit trail of theoretical, methodological and analytical choices. In the present study transitions theory frames the study, as introduced in Chapter 2, and is discussed throughout this text. The mixed methods design supports meeting the study aim and

objectives as described in this chapter, and presented in Chapters 5 and 6 and discussed in Chapter 7. The analytical choices and decisions are described above (Section 4.8.2) and in detail in the following three chapters.

#### **4.9.3 Mixed methods strategies**

##### ***Data quality***

According to O’Cathain (2010), data quality is promoted through transparency, data rigour/design fidelity, sampling adequacy, analytic adequacy and the rigour of analytic integration. Taking each point in turn, data transparency was promoted by describing the methods, the qualitative interviews and the quantitative survey in sufficient detail including discussing the qualitative element as the dominant theme. Data rigour and design fidelity were supported through the implementation of the methods which are described in detail above. The sampling techniques are described above and a discussion of them is presented next in Chapter 5 “Findings I”. The qualitative sample was sufficient to reach the point of theoretical saturation and the quantitative sample size sufficient to provide complementary descriptive and inferential data. The techniques for data analysis were appropriate to the research question. The quantitative data were analysed using descriptive tables and graphs to explore the changes students experienced over time, and inferential techniques applying the GLM were used to suggest influences on transitions over time (Pallant 2010). The qualitative technique of the “Framework” approach (Richie *et al.* 2003) provided the mechanism for coding the data and thematically analysis, an approach appropriate to develop understanding of students’ experiences of transitions. Analytic integration drew together the qualitative and quantitative findings using a thread and weaving approach (Moran-Ellis 2006).

##### ***Interpretative rigour***

Interpretative rigour is concerned with ensuring conclusions are based on the findings (O’Cathain 2010). This was promoted by ensuring the findings were presented separately from each of the qualitative and quantitative threads before conclusions and meta-inferences were made. Care was taken to ensure the inferences were consistent with findings by using a wide range of quotations and a range of graphs and tables and inferential statistics, for example F-ratios and partial eta squared. Inferences made were largely consistent with the theories of transitions reviewed in Chapters 2 and 3 and the conclusions reached in this study may be found by others

in the future, but this cannot be assured until such studies take place. To ensure that the conclusions drawn are more credible than others, the themes which structure the findings, their analysis and synthesis, were supported by the data. Care was taken to ensure that the meta-inferences incorporated both the qualitative and quantitative findings and inferences. Throughout the study transparency of interpretations was supported by processes such as “Framework” and inconsistencies were noted in charts and research diaries. The inferences made were consistent with findings and where the different strands of data indicated differences these were discussed and explained in the final chapter of this study. Throughout the study and its writing up, the purpose of the study and its aim of understanding students’ experiences of transitions remained at the heart of the study and the inferences made.

### ***Inference transferability***

The transferability of the findings to other contexts and settings, groups and individuals has been considered and is presented in the “Limitations” section of the final chapter. However, it is recognised that while the same interviews cannot be repeated by others, in the future researchers can study the transitional process with different groups of students. They can use the same or different methods and use the combination of qualitative and quantitative data from this study to compare with their findings.

## **4.10 Summary**

This chapter explains the mixed methods, cross-sectional, sequential design which was adopted to meet the aim and the objectives of the study:

**Aim:** To understand the work role transition to RN of student nurses who were formerly employed as Health Care Assistants.

**Objectives:**

- 1 To explain students’ experiences of the transition process.
- 2 To explore the impact of work role transitions on students.
- 3 To identify and discuss the facilitators and constraints to transition from Health Care Assistant to Registered Nurse.
- 4 To develop a model to explain the transition from Health Care Assistant to Registered Nurse.

The entire study design was influenced by the mixed methods approach and the ethical conduct of the study lay at the heart of its design. The aim and objectives of the study required approaches which facilitated an understanding of students' experiences when transitioning from HCA to RN but also when changes occurred over time. Consideration was given to qualitative and quantitative paradigms and a mixed methods complementary approach was taken. Together the quantitative numerical and qualitative strands were designed to provide an overall understanding and explanation of the experiences of students with prior HCA work role experience. Samples and sites of data collection were also influenced by the mixed methods design as they needed to be appropriate for both the qualitative and quantitative strands. Different data collection instruments were required and developed (the questionnaire and topic guide) for each strand, each underpinned by the aims and objectives of the study and the literature reviewed. The data were collected sequentially and analyses of the different strands of data were kept separate up to the point of presentation of findings and the discussion when analytic integration took place. Statistical analysis of the questionnaires provided descriptive statistics of the characteristics and experiences over time of the six cohorts of students. Inferential statistical testing was designed to seek out influences on change over time. The interview data were thematically analysed from a sample of students with a range experiences in each of the time and year groups. This was the dominant strand which provided the mechanism for synthesis of the two data strands. The qualitative and quantitative data generated from this study were viewed as not so much different kinds of data but rather the data are students' experiences of transitions formed into words or numbers respectively, which together provide breadth and depth of understanding (Tashakkori and Teddlie 2010). The next two chapters present the integrated findings.

## Chapter 5 Findings I: Context and changing perceptions

### 5.1 Introduction

As outlined in Chapter 4, each cohort of students took part in surveys and interviews at the beginning and end of each academic year. The findings from the data are presented over two chapters; this chapter presents the context and changing perceptions of students with prior HCA experience, and Chapter 6 presents the findings on being a student nurse. The qualitative interview data provided the dominant theoretical drive and generated themes which served as the mechanism to structure and synthesise the findings. The survey data, which is largely numerical, provides complementary quantitative data which is presented in tandem with the themes.

A “weaving” approach to data integration took place. Findings from the qualitative and quantitative data strands are presented and summarised separately, then integrated (Moran-Ellis *et al.* 2006) in an overall summary presented at the end of each theme. The qualitative and quantitative data sets are compared and contrasted to confirm, cast doubt, refute and add insights into students’ work role transitions. Together the two data sets develop understanding of the transition from experienced worker to becoming professionally qualified. They explain students’ experiences of transition and indicate the impact of the process on them. They also identify the constraints and facilitators on transitions of students with prior work experience. Together the data sets point to implications for the organisations which support students’ transitions and of models of work role transitions. The perspectives presented are explicitly those of experienced workers in health care, and implicitly potentially differing from those with no such background. The link across time between perspective and situation is inherent throughout.

In this chapter Section 5.1 introduces the chapter and provides an overview of the sample and student characteristics. Section 5.2 presents Theme 1, “Wanting to be a nurse”, including the subthemes “Getting started” and “Changing perceptions”. Section 5.3 presents Theme 2, “The practice milieu”, which includes the subthemes “Transferability” and “Staff support”. Section 5.4 concludes the chapter.

### 5.1.1 Response rates and characteristics of the sample

#### *Response rates*

Students in each cohort were surveyed at the beginning and end of each academic year, Time 1 and Time 2 (T1 and T2). From each cohort a sample of students took part in a survey. From those who took part in the survey a purposive sample took part in interviews. Table 4.1 provides a summary of the cohorts and the survey responses, rounded to the nearest whole number.

**Table 5.1 Samples and survey responses**

CASTLETON UNIVERSITY (paper and pencil survey)			LOMBARD UNIVERSITY (web-based survey)		
YEAR 1 COHORT					
	T1	T2		T1	T2
No. of students in year group	102	89	No. of students in year group	131	131
No. attended	–	–	No. surveyed	39	42
% attended	–	–	% surveyed	30	32
No. of attendees who completed the questionnaire	19	12	No. who completed the questionnaire	25	26
% of year group who completed the questionnaire	19	14	% of year group who completed the questionnaire	19	20
Total no. of completed questionnaires	31		Total no. of completed questionnaires	51	
YEAR 1 TOTAL COMPLETED QUESTIONNAIRES: N= 82					
YEAR 2 COHORT					
	T1	T2		T1	T2
No. of students in year group	121	–	No. of students in year group	99	99
No. attended	113	–	No. surveyed	24	30
% attended	93		% surveyed	24	30
No. of attendees who completed the questionnaire	25	11	No. who completed the questionnaire	21	26
% of year group who completed the questionnaire	21	–	% of year group who completed the questionnaire	21	26
Total no. of completed questionnaires	36		Total no. of completed questionnaires	47	
YEAR 2 TOTAL COMPLETED QUESTIONNAIRES: N=83					
YEAR 3 COHORT					
	T1	T2		T1	T2
No. of students in year group	73	50	No. of students in year group	131	131
No. attended	56	–	No. surveyed	61	50
% attended	77	–	% surveyed	47	43
No. of attendees who completed the questionnaire	20	19	No. who completed the questionnaire	50	43
% of year group who completed the questionnaire	27	38	% of year group who completed the questionnaire	38	32
Total no. of completed questionnaires	39		Total no. of completed questionnaires	93	
YEAR 3 TOTAL COMPLETED QUESTIONNAIRES: N= 132					
YEARS 1.2.3 COMBINED TOTAL OF COMPLETED QUESTIONNAIRES: N=297					

The total numbers of students sampled at each stage are provided above (Table 5.1) with the exception of Castleton Year 2 Time 2, which were not available from the university despite

several requests. Also, the number of Castleton students in each year group includes students with no prior HCA experience because the university did not record separately numbers of students with and without prior experience. Moreover, response rates are affected by the number of students with prior experience who attended the university on the day the survey took place. They are dependent on students self-identifying that they had the relevant HCA work experience. In addition, Castleton Year 1 Time 1, Year 1 Time 2, Year 2 Time 2 and Year 3 Time 2 group attendance numbers were not recorded because the register was not completed on the day the survey took place.

A number of factors also impact on Lombard students' response rates. The total number of students in each year group is recorded as the same at Time 1 and Time 2 because interim ongoing numbers were not available. Ongoing attrition rates were held regionally and the only numbers available from the central hub of the university were those of students who had successfully completed the year. These numbers included students retaking end-of-year assessments. In addition, response rates were mediated by Lombard students' decisions to not receive survey requests. Only students who agreed to take part in university-approved surveys received the questionnaire. These limitations are discussed further in the final Chapter (7).

The characteristics of all students who agreed to take part in the surveys are presented next.

### ***Respondents' characteristics***

Table 5.2 provides a summary of the characteristics of all the students who participated in this research.



**Table 5.2 Respondents' characteristics (n=297)**

	Castleton University	Lombard University	Total responses
	n (%)	n (%)	n (%)
<b>Respondents</b>	106 (100)	191 (100)	297 (100)
<b>Gender</b>			
Not answered	0	0	
Male	11 (10.4)	19 (9.9)	
Female	95 (89.6)	172 (90.1)	297 (100)
<b>Age</b>			
Not answered	3	0	
Mean (SD)	32.6 (SD 8.9)	39.0 (SD 8.4)	
Minimum	19	20	
Maximum	54	56	294 (98.9)
<b>First language</b>			
Not answered	1	0	
English	85 (80.9)	176 (92.1)	
Polish	0 (0.0)	4 (2.1)	
Shona	2 (1.9)	2 (1.0)	
Yoruba	3 (2.8)	0 (0.0)	
Other	15 (14.2)	9 (4.7)	296 (99.7)
<b>Qualifications</b>			
Not answered	1	0	
<i>Vocational</i>			
NVQ	41 (38.7)	146 (76.4)	
<i>Academic</i>			
GCSE (1–3) or equiv.	71 (67)	135 (70.7)	
A Level or equiv.	46 (43.4)	67 (35.1)	
First Degree	7 (6.6)	4 (2.1)	
Post Grad.	3 (2.8)	4 (2.1)	
Other	28 (26.4)	36 (18.8)	296 (99.7)
<b>Main clinical area as HCA</b>			
Not answered	0	0	
Hospital	29 (27.4)	137 (72.1)	
Community	67 (63.2)	35 (18.4)	
Both hospital and community	10 (3.4)	18 (9.5)	297 (100)
<b>Main patient/client group when an HCA</b>			
Not answered	7	0	
Adults with general health problems	97 (91.2)	182 (95.8)	
Children with general health problems	0 (0.0)	4 (1.3)	
People with mental health problems	0 (0.0)	3 (1.0)	
People with learning difficulties	1 (0.3)	0 (0.0)	
More than one group	9 (3.0)	0 (0.0)	290 (97.6)
<b>Years worked as HCA</b>			
Not answered	0	2	
Mean (SD)	5.3 (SD4.9)	10.5 (SD 7.2)	
Minimum	0.5	1.0	
Maximum	25.0	33.0	295 (99.3)
<b>Academic programme</b>			
Not answered	0	0	
Diploma	69 (65.1)	100 (100)	
Degree	37 (34.9)	0 (0.0)	297 (100)
<b>Year of study</b>			
Not answered	0	0	
1	31 (29.2 )	51 (26.7)	
2	36 (34.0 )	47 (24.6)	
3	39 (36.8 )	93 (48.7)	297 (100)

Table 5.2 summarises the characteristics of students from both universities. It demonstrates that there are unequal student numbers across universities and year groups. The Lombard University students comprise 63% of the total sample and greater numbers of students in Year 3 than in any other year group. More than 90% of students at both universities are females, though the Lombard University students' mean age is 6.4 years more than Castleton University students. English is the first language for >80% of Castleton University students and >90% of Lombard students. The data are collapsed into English speakers and languages spoken by 2% of the sample at individual universities. This also serves as a proxy measure for ethnicity. The qualifications presented in Table 5.2 are aggregated into two main groups, vocational and academic, for discussion purposes. However, it is interesting to note that 113 out of the 297 students sampled hold "A" level or equivalent qualifications and 18 students hold a first degree or postgraduate qualification. The sum of the main clinical areas worked in as an HCA and the main patient/client groups worked with are greater than 100%. This is because students may have worked in more than one "main" clinical area and with more than one patient/client group. The distinction between "Hospital" and "Community" settings is somewhat arbitrary given the diversity and overlap of current health care practice settings. However, the areas indicated on the survey as including "Hospital" were: surgical; operating theatres; maternity; outpatients; medical. Community settings were: nursing home; GP practice; rehabilitation; residential home. Students were also given the opportunity of give details of "other" clinical areas which did not appear in the questionnaire. It is of note is that nearly twice as many Castleton students indicate that they have prior HCA community work experience as Lombard students. This may be due to Lombard students all being seconded and the fact that nursing/residential homes do not feature strongly as sponsors of students. In addition, more than 90% of students at both universities have worked as HCAs with adults experiencing general health problems. Also, no students at Lombard University are recorded as studying for a degree because at the time of this study this option was not available.

Hereafter responses from the survey are aggregated into one data set. This is because the purpose of this study was to capture broad experiences of transitions and was not restricted to students in one setting, rather than to compare universities.

Next, the main findings and the themes found in the data relating to the contexts and changing perceptions of students are presented: “Wanting to be a nurse” and “The practice milieu”. They include associated subthemes and the qualitative and quantitative data strands.

## **5.2 Theme 1: Wanting to be a nurse**

This theme highlights how former HCAs get started on their journey to registration as a nurse, why they want to be a nurse, the impact of studentship, and what they do to keep going. This theme is concerned with commitment and being forced to take courses of action which render students vulnerable to foreseen and unforeseen consequences.

### **5.2.1 Getting started – motivations, risks, assumptions**

#### ***Getting started: qualitative findings***

Students expressed a strong motivation for wanting to be a nurse, which was a long-held inner desire:

“Well the thing is I knew what I wanted to be.”  
John (Time 1 Year1 Castleton University)

“Obviously it was something I always wanted to do...”  
May (Time 1 Year 2 Lombard University)

Interviews also revealed that some former HCAs felt motivated to be a RN because they admired the work they did:

“I’d seen registered nurses perform absolute miracles on the clients. I had seen them resuscitate patients that I thought were gone sort of thing and they have come round and that just fills me with sort of yeah ‘I want a go’ cos it really was a case of ‘wow’.”  
Mike (Time 1 Year 1 Castleton University)

On the other hand, some HCAs felt they could do better than the RNs they had encountered. This and some disdain for their intellectual capabilities gave them confidence to apply for studentship:

“I thought well one of the nurses, I didn’t particularly like the way that she paced [speed of work] and I thought if she can do this and get away with treating people like this and academically she can do this and if she can so can I.”  
Anna (Time 1 Year1 Castleton University)

The quotations on admiration and disdain are from first year students early in their programme. Similar motivations were not expressed during interviews by Year 2 end and Year 3 students.

Another motivating factor for “Wanting to become a nurse” expressed during interviews was enjoying working as an HCA. Implicit in these statements was the assumption that enjoying being an HCA would readily transfer into enjoyment of being a nurse. However, as described below, students explain that they had no real idea or understanding of the role of the nurse when they were working as an HCA. Nonetheless, at the outset of “Wanting to be a nurse” enjoyment of HCA work was a motivating factor:

“I enjoyed the care work and I thought I know I like this and if I do nursing I know I’m going to enjoy it.”

Moyra (Time 1 Year 3 Castleton University)

While there are a range of motivations for individuals wanting to become an RN, students also indicated that wanting to become a nurse involves risk. Students put at risk the financial and/or emotional security of an existing job, exchanging this for the uncertainty of an RN job in the future and “passing” the course. However, in spite of this former HCAs are prepared to take the step into studentship, reasoning that a professional qualification provides the foundation for a career:

“I know perhaps what it would do to my wage but then the outcome is that I am still in the NHS and still get a qualification. And OK there might not be a job in this area for me at the end but at least then I have got the ability or a career to go anywhere else around the world. It’s transferable. So I thought OK it’s now or never ...”

Vicky (Time 1 Year 2 Lombard University)

The sense of apprehension and of grabbing the opportunity to become a nurse was on occasion also accompanied by the fear of not coping and the ignominy of failure. This was felt particularly by seconded students at Lombard University whose contract involved returning to the HCA workplace on a regular basis with an expectation of full return at the end of the programme:

“You know that opportunity doesn’t come along that often and so it wasn’t something that I could say no to regardless of how I coped with it. As it happens I coped with it quite well but, um, going into it, it was quite scary.”

Amanda (Time 2 Year 2 Lombard University)

The desire for more knowledge about nursing and the possibility of career progression was expressed during interviews.

“So yeah for me it is underpinning knowledge and kind of wanting to progress further as a qualified nurse. Not kind of wanting to come in and do my job and go home.”

Vicky (Time 1 Year 1 Lombard University)

Moreover, dissatisfaction with the limited role of the HCA is inferred. However, financial problems, family commitments and life in general had stood in the way of some becoming student nurses, who instead worked as HCAs, but harboured the desire to be a nurse:

“Something I always wanted to do and never got the opportunity in my younger days with a family and just, you know, couldn’t afford to and then eventually got round to it.”  
Dora (Time 2 Year 3 Lombard University)

In summary, the interview data shows that to “get started”, former HCAs’ motivation for wanting to be a nurse can be tied to a long-standing desire. Becoming a nurse was seen as a professional career which involved more than the HCA job. Former HCAs wanted to know more about nursing and to be able to do more, and assumed that enjoying being an HCA would mean enjoyment of the role of a nurse. The interview data also indicated that the desire to be a nurse can be strong. Former HCAs described how they relinquished emotional and financial security for the uncertainties of studentship while risking failure and the ignominy of returning to their former HCA role. Nonetheless, former HCAs were sufficiently motivated to take the step into studentship, which was explored in the survey.

### ***Getting started: quantitative findings***

At discussed at the outset of their journey to registration, students harbour a range of motivations to be a nurse. Table 5.3, taken from Section B of the survey “Becoming a student nurse”, provides a ranked order of reasons for former HCAs wanting to become a nurse.

**Table 5.3 Reasons for wanting to be a nurse**

Q10. Why do you want to be an RN?	Very Important		Important		Not important		Missing	Rank order of importance (Total weighted scores)
	n (%)	Weighted score × 3	n (%)	Weighted score × 2	n (%)	Weighted score × 1	n (%)	
Be able to do more in clinical practice	259 (87.2)	777	38 (12.8)	76	0 (0.0)	0.0	0 (0)	1 (853)
Know more about nursing	258 (87.5)	774	36 (12.1)	72	1 (0.3)	1	2 (0.7)	=2 (847)
Sense of achievement	254 (85.5)	762	42 (14.1)	84	1 (0.3)	1	0 (0.0)	=2 (847)
Career progression	208 (70.7)	624	78 (26.5)	156	8 (2.7)	8	3 (1.0)	4 (788)
Gain academic credit	175 (59.1)	525	94 (31.8)	188	27 (9.1)	27	1 (0.3)	5 (740)
Increased salary	111 (37.6)	333	143 (48.5)	286	41 (13.9)	41	2 (0.7)	6 (660)
Enhanced status	111 (37.6)	333	126 (42.7)	252	58 (19.7)	58	2 (0.7)	7 (643)

Table 5.3 demonstrates that wanting to do more, know more and achieve more in nursing were very important to over 85% of students, with only two students deeming them not important reasons.

Career progression is also significant, with 97% of students deeming it important or very important.

Increased salary and enhanced status are less important to students, with 37.6% ranking them as very important, but almost 20% of students deeming enhanced status as not important. Academic credit, while very important to 59.1% of students, when aggregated with those who think it “important” demonstrates that over 90% of students see this to be a reason of worth.

No matter their motivations for wanting to be a nurse, having embarked on the road to registration students must keep going to reach their ambition of being a nurse.

### **5.2.2 Changing perceptions – mixed emotions**

#### ***Changing perceptions: qualitative findings***

When former HCAs gain entry to programmes of preparation for registration it is the start of a demanding journey. Studentship confers different perspectives of nurses and nursing, as well as on their former role. Veronica at the end of her second year explains:

“It is only when you get into student role ... it's a weird thing um how can I say ... you start to get a chance to see the kind of things... it's almost like a glass partition in that you can see out...”  
Veronica (Time 2 Year 2 Lombard University)

As former HCAs take up the student role they see their old role differently. They see the HCA role as task driven, that the competencies and skills delivered are wide and varied, but the rationale is not fully understood. According to students, HCAs are typically unaware of their limits to knowledge, and revised perceptions of the HCA role impact on how students approach their student role, as Amanda explains:

“Because I had been a health care support worker for such a long time [30years] and no disrespect for health care support workers, we all think we know everything... but then you get into this course and you learn you don't actually know very much at all because you just do what you are told when you are a health care support worker. You don't look at why you are doing it and what the implications and you know that was a

whole different, a retraining really, no I don't know anything and I need to wind back in and get it sorted which is what I did."

Amanda (Time 2 Year 2 Lombard University)

Student nurses from early in programmes see the HCA role as one of limited responsibilities and knowledge compared with the RN:

"If I felt out of my depth you know if I said I don't feel comfortable doing this or I'm not quite sure about this lady but don't know why – they used to kind of take over."

Jill (Time 1 Year 1 Lombard University)

Students recall that as an HCA they felt it was they who did the real work of caring for patients and not RNs:

"You might think oh she's doing paperwork again and I am doing all this work and she has not helped me but there is a reason for that you know the increasing paperwork and one thing or another so no I had no idea at all. I just thought you know that they was just sitting on their bums doing nothing. And now I know that's not true."

Amanda (Time 2 Year 2 Lombard University)

The HCA role then is seen by students as a faceless support role, where individuals are not encouraged to ask questions:

"You don't ask questions, it looked as though you were showing off. You became faceless."

Vicky (Time 1 Year 2 Castleton University)

Alongside a revised view of the HCA role, students also revise their views of what it means to be an RN. Their perceptions change as they move from a support role to learning to be an RN. Students explain that as HCAs they did not understand the scope of the role, the knowledge needed, the responsibilities involved and the accountability incurred. The lack of understanding of the role, once recognised, could lead to students feeling overwhelmed:

"I don't think I realised half of what goes into you know the training and the practice. All the girls I work with make it look so effortless ... Now that my eyes have been kind of opened up for how much they do it is sometimes a bit overwhelming."

Mary (Time 2 Year 1 Lombard University)

Across time and year groups, students recall that as HCAs they saw their role as similar to that of the RN. Many felt that with prior HCA experience they would be able to take up the role of the RN with little difficulty. As discussed in Chapter 1, HCAs are currently trained to perform a wide range of tasks which were formerly the sole domain of RNs. Students reported that they believed the only difference between the roles of HCA and RN was that RNs dispense medications and write reports:

“Well I would have said when I was prior when I was thinking about training “ah sure there is not much difference” maybe doing a report and doing evaluations and doing injections and CDs and there is not much difference between what you are already doing and that is not the case it is not...”

Anita (Time 2 Year 2 Lombard University)

Once a student, former HCAs quickly see the differences between roles, causing anxiety at the prospect of registration:

“I didn’t realise exactly how much a nurse (a) had to do and how much they were responsible for. Responsibility has really hit home ... I had a really narrow view of nursing. I thought nurses were you know a bit of health promotion perhaps giving injections and suppositories, enemas and basically being the doctor’s dogsbody, is what I thought it was. This is the front line, the shop floor...”

Anna (Time 1 Year 1 Castleton University)

Cath also comments on her former lack of role awareness. Formerly, she too was unaware of the broad range of RNs’ work but was also unaware of stresses inherent in the role:

“I think the surprise was how much pressure they are under and how you know they kind of seem to get the blame for everything. There is a lot more that they do than people acknowledge.”

Cath (Time 1 Year 2 Castleton University)

The limited understanding of the role impacts on some students who see the RN role as having limited patient contact time, and bemoan it. This causes former HCAs to question if they have made the right career decision, and adds to their difficulties:

“Having that one to one time, able to socialise whilst you were doing your job, but having that ability yes to have a laugh and have a joke ... It took me quite a while to the point that even when I got to the end of the first year when I thought that is this really what I want to do.”

Vicky (Time 1 Year 2 Castleton University)

One explanation of lack of understanding of the role of the RN is offered by Carol. She perceives that the task focus of the HCA role leaves incumbents little time to observe and understand the RN role:

“Yeah [sounds regretful] ... because you are so busy as an HCA that you actually don’t observe what everyone else is doing anyway so that is the main reason.”

Carol (Time 2 Year 3 Lombard University)

Although the differences between the roles are perceived early in their studies, for one student at least the prospect of what it is to be accountable hit hardest after completion of studies and being interviewed for a permanent RN post:

“Yeah I think in the last year I used to think it will not be that bad but until I went on the interview and they ask me about responsibility what makes the difference from being a



student nurse and a registered nurse [...] and responsibility and accountability for your actions and it begin to get me worried and scared.”  
Bettina (Time 2 Year 3 Castleton University)

Across the time and year groups students expressed excitement as well as fear of taking up the role of the RN:

“I’m excited for it but at the same time I’m nervous about it too, when I will be accountable for my own actions and other people’s actions.”  
Mike (Time 1 Year 1 Castleton University)

“Scary but exhilarating at the same time.”  
Susan (Time 2 Year 2 Castleton University)

Mixed emotions were still evident in Year 3:

“Erm well yeah, no, yeah no [laughs] Yeah I am. I am looking at it positively you know. It is quite daunting. I know things can go wrong, it’s one of the risks you have to take I think.”  
Terry (Time1 Year 3 Castleton University)

Nonetheless students were determined to keep going in spite of their fears:

“Petrified, I am petrified. I am not going to waste the last four years and I know that I will be OK but I really am scared... well it is the responsibility.”  
Tanya (Time 2 Year 3 Lombard University)

Mixed emotions were also experienced in the academic segment of studentship. Fears of not being able to cope academically and feeling too old to be a university student were expressed by some. On the other hand, excitement, pleasure and elation were also felt:

“Mixed emotions. I thought oh my God have I done the right thing. Then I thought oh my God I have got to get back into studying again which at the tender age of say 35 it was ooohhh can I really do this [...] and so yes I was pleased at getting in but at the same time oh what have I done.”  
Veronica (Time 2 Year 2 Lombard University)

Students also felt proud of achieving acceptance on to pre-registration programmes. They described feeling different and felt that they were treated differently by colleagues. These perceived differences were articulated by Anita, who had HCA experience in the setting where she took up the student role for the first time:

“I was very kinda very you know proud of myself I suppose to change into a different uniform, a white uniform instead of lilac pinstripe, and you know at the time I felt different and I certainly was treated differently by the professionals. Suddenly I was visible.”  
Anita (Time 2 Year 2 Lombard University)

The change of uniform was the most obvious indicator of changed status and was reflected in the interactions students had with colleagues who had formerly seen and treated them in a different way when they were HCAs.

The reality of studentship, the changes it engendered and its academic and clinical demands, particularly in the first two years of studentship, left students feeling shocked:

“I think it was a shock to my system ... it was all you know when we first started it was all very nice and slow and all of a sudden it was wham you have to do all this ...”  
Cath (Time 1 Year 2 Castleton University)

However, by Year 3 students are able to manage a high workload:

“I think it was within three months, the assignment, the project, the portfolio and then the management.”  
Bettina (Time 2 Year 3 Castleton University)

Students endeavour to find ways of keeping going during the journey to registration. They feel their life is taken over by the demands of the programme – a feeling primarily articulated early in the programme.

“It is hard, yeah really hard [laughs] because I don't have time don't have much time to manage with my social life... I feel deflated sometimes... I don't know – it's OK.”  
Steve (Time 1 Year1 Lombard University)

The demands of the programme result in stress for individuals and their families and friends who also make sacrifices to facilitate students through the process of transition to RN:

“Yes the course completely takes over. My life is not mine. Not at the moment... he [the husband] says I am a lot more stressed out ... my temper is a lot more short at home um and he says I can't wait for this bloody course to finish. He's always saying that.”  
Annya (Time 1 Year 2 Castleton University)

Many students feel they could not get through the programme without the support of family and friends, but also their peers, helping them to manage the transition:

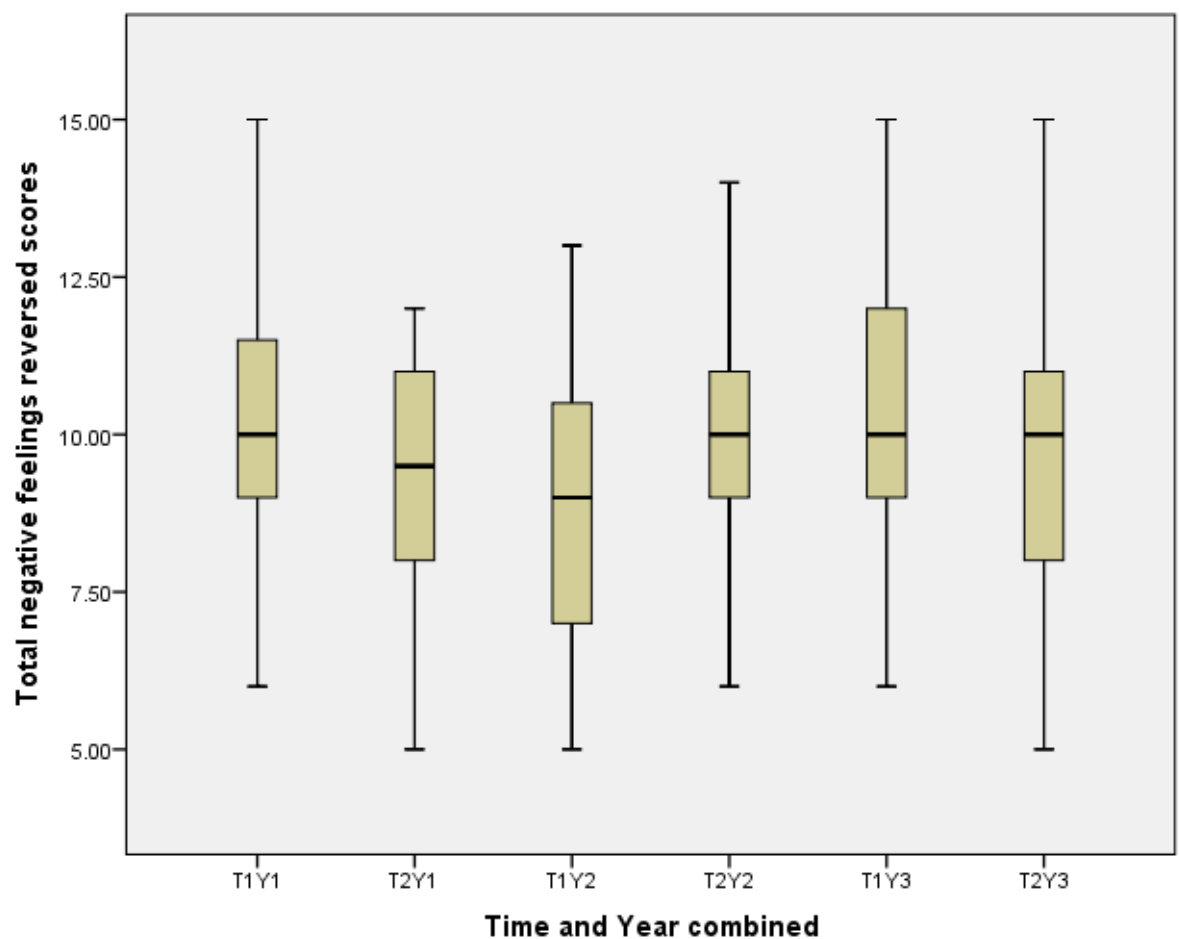
“There wasn't one week went past when there wasn't one of us crying and saying that we were leaving [laughs] honestly yes and the other said no you are not leaving we are doing it together.”  
Tanya (Time 2 Year 3 Lombard University)

The findings from the interviews demonstrate that very quickly, and contrary to their expectations, students see that their former HCA role is very different from the role of the RN. They come to see the HCA role as task orientated, lacking underpinning knowledge and of limited responsibility. Students with prior HCA experience did not understand the RN role and its scope before taking

up the role of student. Across time and year groups students experienced both fear and excitement at the prospect of taking up the role of RN. Students also felt overwhelmed by the demands of studentship, although by the end of Year 3 they were able to cope with high demands. Across time and year groups students drew support from family, friends and peers. The journey to registration was one of changing perceptions and strong mixed emotions.

### ***Changing perceptions: quantitative findings***

Students were asked about how they felt about being on the programme. Question 11 grouped items into positive and negative feelings and high scores indicated high negative feelings and high positive feelings. As noted in Chapter 4, MPlus “Promax factor loadings” demonstrated the same construct was being measured in Question 11 for items 1–4 and 6–9: negative and positive feelings and “Stress” correlates with negative feelings (Appendix 4.3). Negative feelings across time and year groups are presented first (Figure 5.1), with high scores recording students with high negative feelings.



**Figure 5.1 Negative feelings felt across time and year groups**

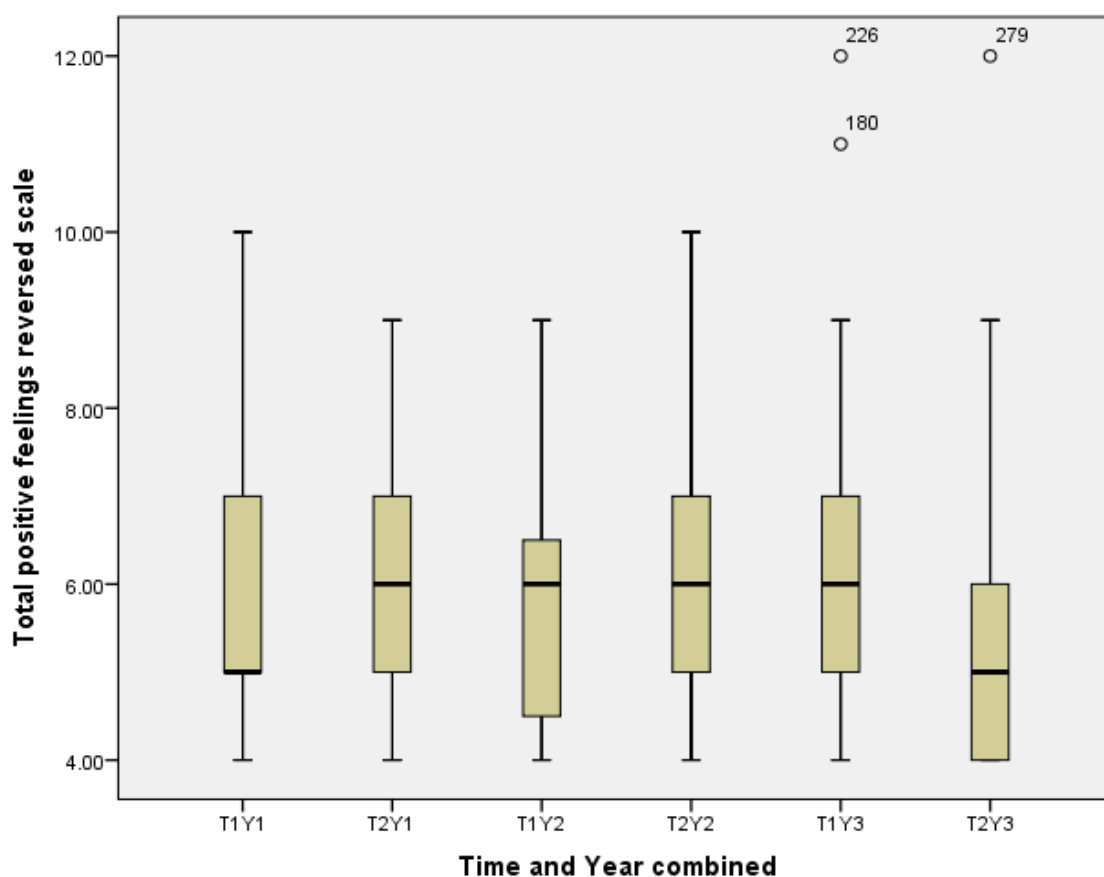
Figure 5.1 summarises the median, upper and lower quartiles and minimum and maximum data values. The length of the box indicates the variables interquartile range and contains 50% of the cases. The line across the middle of the box represents the median value. The whiskers protruding from the box extend to the smallest and largest values.

Across all time and year groups students' median scores (10.00; 9.50; 9.00; 10.00; 10.00; 10.00) were remarkably consistent in reporting negative feelings: apprehensive; anxious; stressed; fearful. The upper interquartile range indicates high scores at the beginning of studies, falling to its lowest point at the beginning of Year 2 before slowly moving up and regaining high levels by Year 3. The lowest quartile levels were recorded at the beginning of Year 2 and increased thereafter.

On a possible score range of 5–15, students' mean scores over the six time periods were: 10.05 (SD 2.07); 9.31 (SD 1.95); 9.11 (SD 2.24); 9.91 (SD 1.89); 10.32 (SD 2.37); 9.65 (SD 2.51). On the three-point Likert scale with a possible range of 5–15, the mean scores indicate that negative feelings were persistent and did not show great variation across the time and year points around the mid-score of 10. Moreover, the standard deviation, which is the average variability or spread of the data, did not show great variation across time and year groups.

At the same time all groups were asked to score positive feelings: optimistic, motivated, enthusiastic and exhilarated (Figure 5.2).

Figure 5.2 shows that the interquartile median scores for positive feelings were low and with little variation across time and year groups, but lowest at the beginning and end of programmes: 5.00; 6.00; 6.00; 6.00; 6.00; 5.00. The lower quartile shows that positive feelings were low throughout the programmes, particularly at the beginning and end. At the final time point the bottom whisker hits the floor, indicating that 25% of students' median scores were < the median score of 5.00. However, the upper quartile was exceeded by three students in Year 3, but nonetheless upper quartile scores do not reach the ceiling in any time or year group.



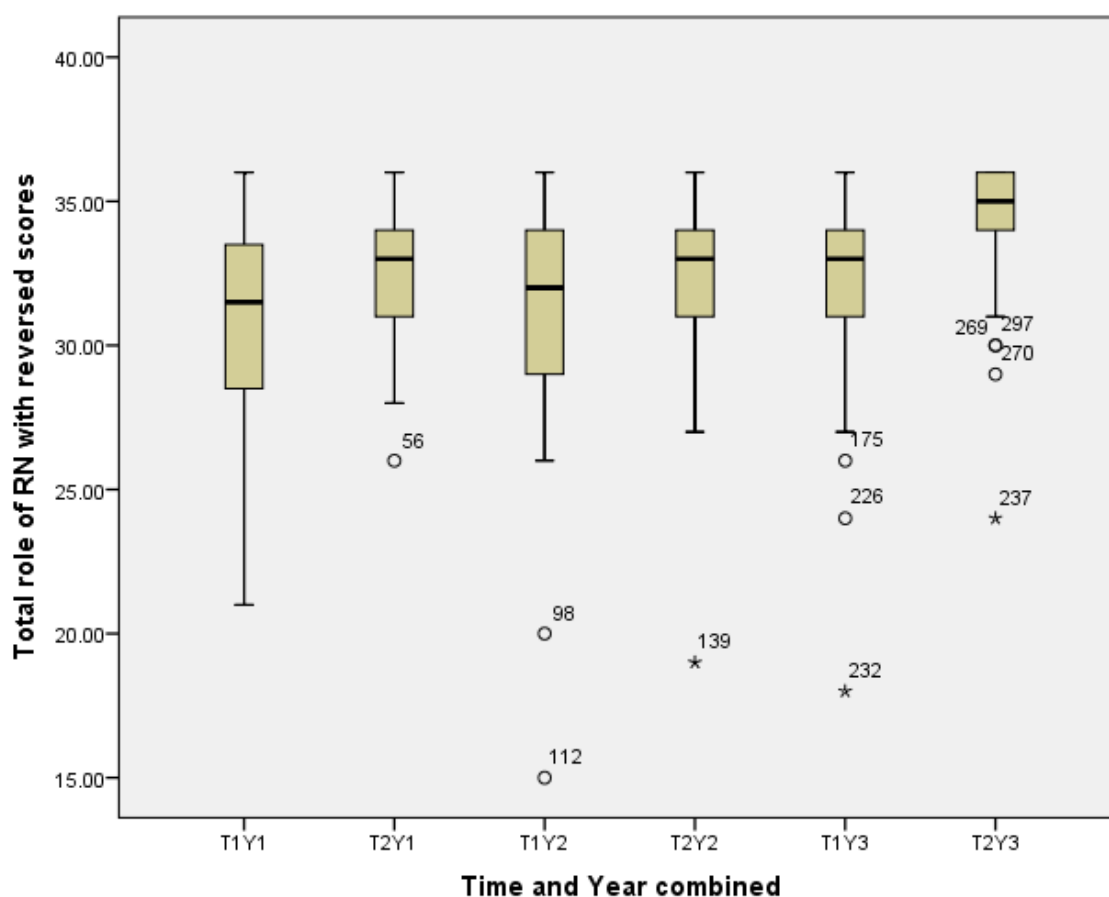
**Figure 5.2 Positive feelings across time and year groups**

Figure 5.2 also demonstrates, from a slightly different perspective, that from a possible score range 4-12 students scored lowest at the beginning and end of programmes. The mean scores were consistently low across the 6 time and year points: 5.95 (SD 1.61); 6.03 (SD 1.57); 5.70 (SD 1.41); 5.89 (SD 1.66); 6.10 (SD 1.84); 5.39 (SD 1.58) and the average spread of the data (standard deviation) were similar and small.

Alongside positive and negative feelings, students' feelings of professional confidence were explored. Registration as a nurse carries with it responsibilities and accountabilities, and Figure 5.3 indicates how confident former HCAs felt in upholding the professional role of the nurse. The scale consisted of 12 key items taken from the NMC "Code" (Cronbach's alpha =0.860) with a range of possible scores from 12 to 36.

Figure 5.3 shows the interquartile median scores (range 12–36) consistently high across time and year groups (31.5; 33.00; 32.00; 33.00; 33.00; 35.00). A small number of outliers were evident in the lower quartile but none in the upper. Lowest scores were at the beginning of programmes and

the start of Year 2. A very high score was found at the end of studentship, with the upper whisker (high values) hitting the scale ceiling. Concerns were raised when the distribution of the GLM residual (difference between the observed value and the value predicted by the model) and the QQ test for this scale showed some small deviation from the expected normal distribution. A Bootstrap analysis revealed small biases (mean difference >3.87; bias >.020), so the standard QQ analysis is presented in Appendix 5.1.



**Figure 5.3 Professional confidence**

In summary, the survey data on “changing perceptions, mixed emotions” indicates that students’ confidence to uphold the key tenets of the NMC Code of Conduct was high across time and year groups and in particular very high just before students registered as a nurse. However, across time and year groups negative feelings showed little variation around a mid-score mean, while positive feelings were low, in particular at the beginning and end of programmes (T1 Y1 and T2 Y3).

### **5.2.3 Theme 1 summary: Wanting to be a nurse**

The theme of wanting to be a nurse shows how former HCAs get started and keep going on the road to nurse registration. The interviews highlighted that a strong motivation for getting started was harbouring a long-held ambition to be a nurse. The survey data provided specificity, showing that wanting to know and do more about nursing were very important motivations. Both data sets also showed that career progression was important. The survey data demonstrated that academic achievement and increased salary were important motivations, although increased salary did not emerge as important during interviews. The interview data did however reveal that the step into studentship requires commitment on the part of former HCAs. They give up the financial and emotional security associated with their prior role and experience fear and anxiety when taking up the role of student nurse. The interview data also indicated that students felt overwhelmed and shocked by the demands of studentship, particularly in the first two years of their studies, and throughout their studies drew support from family, friends and peers to keep going.

The interview data also indicates that former HCAs' perceptions of the HCA role and that of the RN changed considerably when studentship commenced. They came to see the HCA role as task orientated, lacking underpinning knowledge and one of limited responsibilities where limitations were not acknowledged and understood. Students explained that the role of the RN was not what they had expected. As HCAs they explained that they did not understand the RN role and as students quickly realised that their former experience did not prepare them as they had expected it would. However, the survey data also showed high levels of confidence in upholding key aspects of the professional role of the RN across all time and year groups. This confidence was highest at the end of the programme (Time 2 Year 3), but at the same time point interviews indicated that students were also feeling "petrified". In fact, mixed emotions were expressed across all time points and cohorts during interviews. The survey added specificity, indicating that negative feelings median and mean scores at around the mid score of 10 (possible range 5–15) did not show great variation across time and year points. At the same time positive feelings were low, in particular at the beginning and end of programmes. This theme indicates that wanting to be a nurse involves motivations, risks, misconceptions, changing perceptions and expectations and mixed emotions.

Before becoming a nurse former HCAs must successfully negotiate the clinical placements they are sent to as a student nurse. Their experiences and perceptions of these settings are the subject of the next theme.

## **5.3 Theme 2: The practice milieu**

This theme focuses on the practice settings which comprise students' learning environments. It is concerned with changes in students' perceptions and experiences of contexts, structures and roles, as their role within the nursing team changes.

### **5.3.1 Transferring prior experience**

#### ***Transferring prior experience: qualitative findings***

Students spoke of the impact HCA experience had when the clinical setting they were allocated to as a student was the same as, or similar to, their former workplace. Students can feel more confident about their performance and less anxious and worried in the student role. It can also result in accelerated learning opportunities:

"You are not as nervous as um as if you have never done care work. You have some idea of the basics you know, washing and dressing and um toileting and feeding you know the basics because I think some of those can be quite nerve wracking if you have never done them before, if you think back to the first day you go into care really. So because you've got those basics I found some of the nurses allowed me to do other things quicker that maybe some of my peer members didn't do, things like erm the medication rounds and I even did some things like working alongside whoever was in charge of the ward that day as well erm things that maybe others didn't do quite so quickly."

Moyra (Time 1 Year 3 Castleton University)

However, not all students found their prior experience was the advantage they had expected it to be, and neither did it ease their pathway to registration as they had presumed it would:

"Yeah I thought I'd do that course and breeze it but you didn't ..."

Sally (Time 2 Year 1 Castleton University)

Moreover, contrary to students' expectations, prior experience can be a constraining influence. For example, prior HCA work in primary care, such as in outreach teams, nursing homes and rehabilitation hospitals, did not provide a good basis for studentship, particularly in early acute hospital placements. The different work milieu can be a shock to former HCAs and prove a stressful and confidence-sapping experience. Even work experience in acute care can be of little or no help in different acute settings. Less prominent is the reverse situation, when students move from secondary to primary care.



At the start of studentship, being an experienced HCA gives way to the stress which accompanies becoming a novice student with limited understanding of the milieu:

Interviewer            "So even with three years' HCA experience you were still finding it stressful?"  
Annya                    "Yes because it was so, so different to the nursing home"  
Interviewer            "Um, what was most different about it?"  
Annya                    "Oh God, everything"  
Annya (Time 2 Year1 Castleton University)

Dora explains how the shock of being placed in an unfamiliar setting dented her confidence, an experience she was still able to recall in her final year of studentship:

"It was like, I [was] just like a fish out of water... erm, basically no confidence whatsoever. Just a nightmare because I have never worked in a hospital environment before."  
Dora (Time 1 Year 3 Lombard University)

Not just the setting but the ways in which registered nurses perform their duties can be perceived as incongruent with prior experience, and this can be upsetting:

"I haven't liked a lot of the hospital wards at all, um I just think the nurses are completely different to what they are in the community."  
Joan (Time 2 Year 2 Castleton University)

Even prior experience working within an acute care setting can mean the type of experience gained is of little use early in hospital placements. For example, David had worked as an HCA in a minor injuries unit where he was trained to perform a number of procedures including applying plaster of paris casts, and performing venepuncture, cannulation and ECGs. However, when placed on an acute hospital ward for the first time as a student nurse he did not want to go. He describes how his prior experience did not transfer easily to the new setting, leaving him feeling uncomfortable and incompetent:

"The basic nursing care, feeding patient, washing patient, taking to toilet, getting patients up, I hadn't come across that before and I remember when they gave me the placement I didn't want to go, I felt really out of my comfort zone. From my first shift there I felt like I shouldn't be there because I didn't know nowt, didn't know nothing. I didn't know where to go and what to do and remember walking about with my mentor and she said the patient in bed 6 needs help washing and dressing and do that, I will be with you in a moment. I remember standing there and thinking right where do I start?"  
David (Time 1 Year 2 Lombard University)

Even when clinical skills needed for care have been acquired as an HCA, when practised in different settings they may not transfer easily, for example, when moving from hospital to community settings. This too can have an effect on students' confidence:

"Knowing the basic care, washing the patient and things like that first, but the community, I think now that was quite new to me. I felt a little bit of time to get my head into it and get my confidence up."

Kim (Time 2 Year 2 Castleton University)

Students assume at the start of programmes that prior HCA experience will ease their transitions. However, even the acquisition of relevant clinical skills which readily transfer to early placements can be a short-term advantage:

"We were saying at the time [Year 1 start] that we felt that it would perhaps do student nurses no harm, I don't know, six months or a year, however long, to just to have that underpinning knowledge as an HCA first, you know what I mean? That ground work erm but whether I feel like that now in our second year I don't know. I don't feel as if they have been left greatly behind us now."

Brenda (Time 1 Year 2 Castleton University)

HCA work, although always present as a background, can be discounted as studentship progresses:

"I don't use that experience any more. I think it you know it all adds up and it makes you the nurse you are or the nurse that you are going to be ..."

Moyra (Time 1 Year 3 Castleton University)

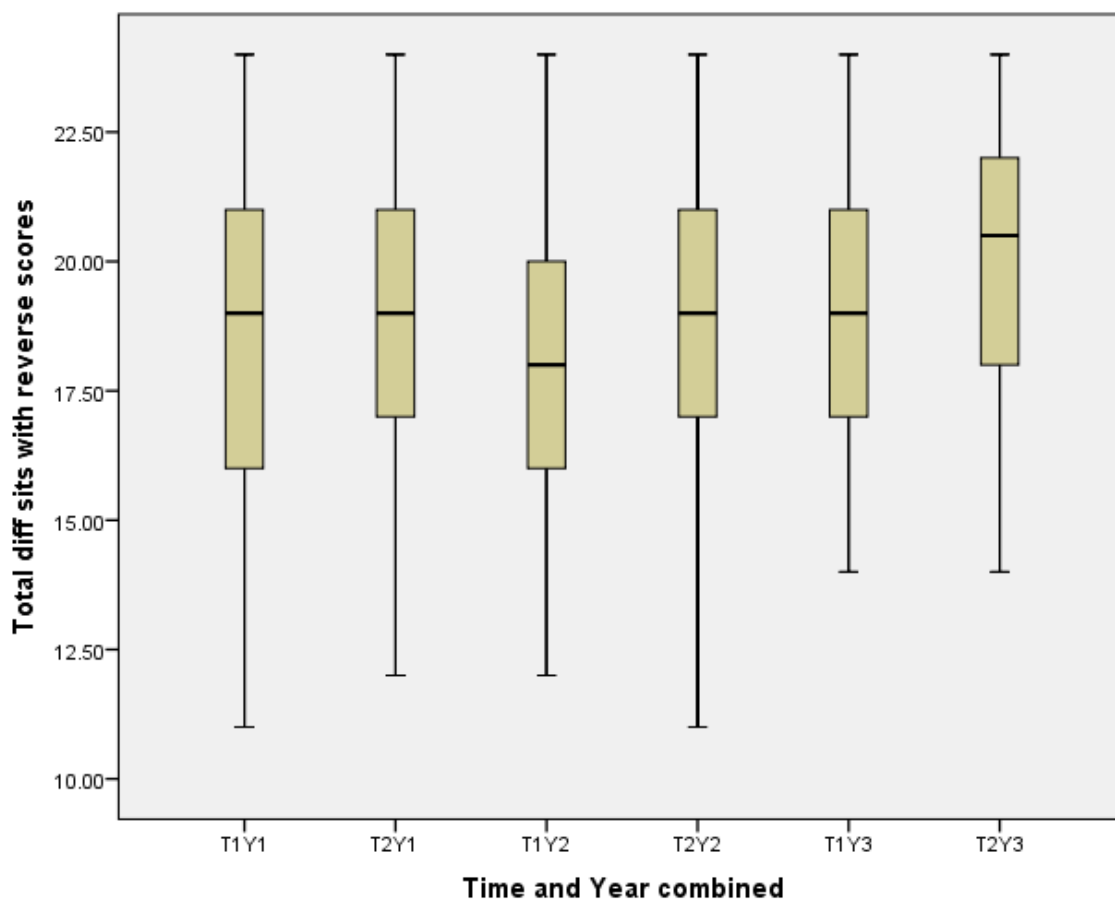
The interview data on transferability found that while prior experience could help in practice settings early in studentship, this was not automatic or inevitable. If the workplace where HCA experience was gained was different from the student's clinical placement, particularly in Year 1, they can feel unsure, anxious and stressed. Their clinical confidence can be shaken when they perceive that prior experience does not prepare them for the student role as they had expected.

### ***Transferring prior experience: quantitative findings***

Given their prior experience, students were asked in an 8-item scale (Cronbach's  $\alpha = 0.786$ ) adapted from Pisante *et al.* (2008) how confident they felt in dealing with difficult situations nurses encounter (Figure 5.4).

Figure 5.4 shows median interquartile scores (range 8–24) consistently high across time and year groups: 19.00; 19.00; 18.00; 19.00; 19.00; 20.50. The upper quartile reached similar levels at all time and year points, although lower quartile confidence levels were lowest at the start of

programmes and at the end of Year 2. Mean scores were: 18.52 (SD 3.00); 19.05 (SD2.81); 18.20 (SD3.18); 18.76 (SD 3.06); 19.03 (SD2.79); 20.21 (SD2.41). These reflect again the high level of confidence felt across the time and year groups. The lowest mean of 18.20 was scored at the beginning of Year 2, and the highest before registration of 20.21, reflecting the medians. No student across time and year groups felt “not confident” in all eight items in the scale.



**Figure 5.4 Clinical confidence: dealing with difficult situations**

As well as students being asked about their confidence in dealing with difficult situations, they were also asked in a group of five individual items how their clinical skills had changed since beginning programmes (Table 5.4).

**Table 5.4 Clinical skills: change since the beginning of programmes**

		<b>T1 Y1</b> <b>n (%)</b>	<b>T2 Y1</b> <b>n (%)</b>	<b>T1 Y2</b> <b>n (%)</b>	<b>T2 Y2</b> <b>n (%)</b>	<b>T1 Y3</b> <b>n (%)</b>	<b>T2 Y3</b> <b>n (%)</b>
My range of clinical skills has increased	Agree	29 (63.6)	34 (89.5)	39(84.8 )	31 (83.8)	62 (88.6)	57 (91.9)
	Slightly agree	14 (31.8)	4 (10.5)	6 (13.0)	5 (13.5)	6 (8.6)	3 (4.8)
	Disagree	2 (4.5)	–	1 (2.2)	1 (2.7)	2 (2.9)	2 (7.2)
I now know more about clinical nursing	Agree	26 (59.1)	34 (84.2)	41 (89.1)	32 (86.5)	66 (94.3)	57 (91.9)
	Slightly agree	16 (36.4)	6 (15.8)	5 (10.9)	3 (8.1)	3 (4.3)	3 (4.8)
	Disagree	2 (4.5)	–	–	2 (5.4)	1 (1.4)	2 (3.2)
I have lost some clinical skills	Agree	32 (72.7)	30 (78.9)	30 (65.2)	26 (70.3)	58 (82.9)	50 (80.6)
	Slightly agree	8 (18.2)	6 (15.8)	9 (19.6)	8 (21.6)	9 (12.9)	5 (8.1)
	Disagree	4 (9.1)	2 (5.3)	7 (15.2)	3 (8.1)	3 (4.3)	7 (11.3)
I can analyse situations in clinical practice	Agree	19 (43.2)	26 (68.4)	26 (56.5)	19 (51.4)	50 (71.4)	53 (85.5)
	Slightly agree	24 (54.5)	12 (31.6)	20 (43.5)	17 (45.9)	20 (28.6)	9 (14.5)
	Disagree	1 (2.3)	–	–	1 (2.7)	–	–
I feel confident I can pass clinical assessments first time	Agree	8 (18.2)	17 (44.7)	16 (34.8)	13 (35.1)	28 (40.0)	41 (66.1)
	Slightly agree	28 (63.6)	20 (52.6)	30 (62.2)	20 (54.1)	37 (52.9)	19 (30.6)
	Disagree	8 (18.2)	1 (2.6)	–	4 (10.8)	5 (7.1)	2 (3.2)

There was no missing data but percentage changes due to unequal numbers at the cohort time points are discussed below. Percentage changes indicated that students' range of clinical skills increased over time. The number of students who agreed their skills had increased was lowest at Time 1 Year 1 and highest in Year 3 (Time 1 Year 3: 87%; Time 2 Year 3: 92%). By the end of Year 1 (Time 2 Year 1), agreement that skills had increased rose quickly to above 89%, and it remained at 84–85% throughout Year 2. This pattern was also evident when students were asked about knowing more about clinical nursing. The lowest percentage agreement recorded was at the beginning (59%); there was then a sharp rise at the end of Year 1 (84%) and percentages remained high in Year 2 (87–89%). At the end of programmes, agreement was 94% (Time 1 Year 3) and 92% (Time 2 Year 3) and once again a slightly higher percentage was recorded at Time 1 than at Time 2. A similar pattern was recorded when students were asked if they agreed they

could analyse situations in clinical practice. The lowest percentages were recorded at Time 1 Year 1 (43%), the highest at Time 2 Year 3 (86%). Similarly, there was a large jump at the end of Year 1, but then a drop followed by increases up to the start of Year 3. There was a large percentage increase (20%) in agreement at Time 1 Year 3 and 14% more than that agreed at Time 2 Year 3.

The general pattern of low scores at the beginning and high scores at the end was repeated when students were asked how confident they felt they could pass clinical assessments at first attempt. The lowest score was at Time 1 Year 1 (18%) and highest at the end of programmes (66%). There was again a sharp rise in agreement at the end of Year 1 (44%) followed by 34–40% recorded up to Time 1 Year 3. However, although the percentage rose to 66% at the end of programmes (Time 2 Year 3), a third of students were not in full agreement they could pass at first attempt. Moreover, when rating if they had lost clinical skills across programmes, 65–85% agreed, with the highest percentages recorded at the end of programmes as students moved furthest away from their former HCA role.

In summary, quantitative findings of experiences of dealing with difficult situations which nurses' encounter was high and varied little across time and year groups. When asked if clinical skills had increased, the lowest percentage agreeing was recorded at the start of programmes, and the highest in Year 3. There was a large jump in agreement at the end of Year 1. This pattern was repeated when students were asked if they now knew more about clinical practice, could analyse clinical situations and how confident they were in passing clinical assessments at first attempt. In Year 2 percentage rates remained high and increased in Year 3.

In addition, when asked if they had lost clinical skills across programmes, 65–85% agreed with the highest percentages recorded at the end of programmes as students moved furthest away from their former HCA role. Also, although as noted above 66% of students at Time 2 Year 3 agreed they were confident they could pass clinical assessments at first attempt, 33% were not.

### 5.3.2 Support for learning

#### ***Support for learning: qualitative findings***

Clinical staff who support and teach students influence how students experienced role change. Their actions and attitudes can facilitate or constrain students with prior experience and their progress. Prior experience can result in students feeling they are more likely to be used as a pair of hands than students without prior experience, particularly for students who return to the setting where they were formerly employed as HCAs. However, being used as a pair of hands was widespread and perceived as a constraint to learning by students in all time and year groups:

- |  |   |
|--|---|
| Anita                                    | "...it is the culture because if you are a student and there is staffing problems and the restructuring and the shift in management and everything else so that is an ongoing thing..." |
| Interviewer                              | "But I think my question to you is do you think you are more likely to be called in as one of the numbers because you have had the experience?"   |
| Anita                                    | "Yes, yes definitely (sighs) yes, yes."   |
| Anita (Time 1 Year 2 Lombard University) |   |

Students also reported being put on the roster to do HCA work:

- "So sometimes you find you are put down to work and none of your mentors are there and you wonder who am I going to work with. They just put me down because they are short staffed because they haven't got enough HCAs. Yes. So it happens sometimes. Especially at the weekends."
- Simone (Time 1 Year 3 Castleton University)

Just as being put on the roster to work as an HCA signifies, other actions by staff in clinical practice also have an important impact on students which can facilitate or constrain learning. Permanent staff not only teach students clinical skills but also socialise them in preparation for their future role as an RN. A variety of staff were referred to during interviews such as RNs, doctors and other members of the health care team including dieticians and physiotherapists, HCAs and managers. However, students indicate that mentors have the greatest impact on their learning. Mentors' influence is so strong that, as Susan states: "they can make or break a placement (Susan, Time 2 Year 2 Castleton University).

Inherent in their role is the power of mentors to pass or fail students on placement. Students feel constantly observed and this can be demanding:

- |             |  |
|-------------|--|
| Sharon      | "Yes they have eyes everywhere, mentors do, even when they are not there they have eyes" [laughs]. |
| Interviewer | "Someone else's eyes?"   |

Sharon "Yes, you have to be on your best behaviour every hour of every day of every minute. Yep."  
Sharon (Time 2 Year 3 Castleton University)

However, students are clear which mentor performances facilitate their progress. Time is a key issue. Spending as much time as possible with mentors is seen as important and prior experience does not reduce students' need for support. They manage the situation by endeavouring to work as much as possible with their mentors:

"Because it's an area I've never worked in before and she's been fantastic and I've worked with her every single shift and adapted my shifts around her and done a couple of long days with her so I could stay with her. So it's been really good."  
Helen (Time 1 Year 1 Lombard University)

Second and third year students also need support, and time working with their mentor is important for their development:

"The sister was my mentor and she did not have time at all because she was a brilliant sister and I picked her brains and I tried and I tried and I tried and erm but she would literally walk away mid-sentence you know and so then I stuck with the rest of the staff you know to get to achieve my goals."  
Anita (Time 2 Year 2 Lombard University)

Over-burdened mentors, albeit with good knowledge but insufficient time, perhaps inadvertently, can act in demeaning ways, providing a poor role model, for example, failing to adhere to common courtesies. When RNs take up the role of mentor there are expectations of typical responses they will make in that role. As demonstrated in the quotation above and again below, individual mentors' actual role performance can depart from the normative role considerably. A lack of respect and demeaning attitudes can also stand in the way of students developing confidence:

"I was in my second placement in my first year, and when we were doing the drug round err I didn't know many drugs at that point, she would ask me in front of all the patients, what this drug is. What is it used for? And I said to her look I don't know. ...and she would start laughing as if to say oh my God you don't even know this, you know..., she was actually leaving and I had another mentor and she would say you are lucky I am not going to be your mentor for the rest of the placement. I would give you a bad grade. You know you get a lot of nastiness."  
Terry (Time 1 Year 3 Castleton University)

The mentor knowingly discredits the student in front of the very audiences students wish to be seen by as credible practitioners. As Terry states, this sort of debasement experience is not an uncommon one.

In contrast, a positive attitude by mentors and staff is identified by all groups of students as facilitating. Students feel the need to be encouraged and receive feedback:

"They were always so encouraging, they would tell if you didn't do something well."  
Sally (Time 2 Year 1 Castleton University)

When mentors do not want to teach this has an impact on students who, in spite of their prior experience, perceive they do not possess sufficient knowledge. Students feel disadvantaged through lack of support and being presented with a poor role model:

"I didn't feel that she wanted to teach me and the fact that I didn't know and not a lot of skills and I sort of felt very unsupported and it made me feel well how can you be a good nurse if you are not because you have to teach the students and pass on your knowledge and she wouldn't do that."  
Kim (Time 2 Year 2 Lombard University)

On the other hand, former HCAs may possess clinical skills which are deemed unsuitable for student nurses to perform in the practice milieu. If mentors and other staff take into account students' prior HCA experience they can provide appropriate support such as reminding students what they can and cannot do when in the student role. A first year student gives an example:

"She knew where I was coming from when I said on a few occasions that I was not sure what I should be doing because I was not sure what I was allowed to do. On some things I was allowed to do less and some things I was allowed to do more ..."  
Mike (Time 1 Year 1 Castleton University)

During the course of interviews, students described a number of teaching techniques used by mentors which facilitated learning. They included questioning, setting quizzes, providing reading and suggesting reading, sometimes during but most often outside of practice time. Students perceived that although they had prior HCA experience and may have been deemed competent, for example by NVQ skills testing, they did not possess sufficient underpinning knowledge. Questioning was felt helpful to facilitate the move away from task orientation:

"Yes she was really, really helpful. And she kept on asking me sort of questions ... she would ask me so why are you doing it this way? And I like that it makes you know why you are doing it you are doing it you know, not just for the sake of doing it."  
John (Time 1 Year1 Castleton University)

However, when students felt their prior experience was not recognised they felt demotivated and this could result in the opportunity to build on that prior experience being denied:

"They treat you as if you don't know anything and there have been times when I have known things, especially wound dressings because you get a lot [in the community], and in the hospital and they have been sort of no we deal with it. And they have no idea about the dressings what goes on what. It just makes you feel, I don't know um low at times you know."  
Joan (Time 2 Year 2 Castleton University)



Denying the value of prior experience also makes students feel low. Discussion with mentors about previous experience is important to help students to identify appropriate learning outcomes and for mentors to provide appropriate support. This might include working towards outcomes outside expected norms. Susan explains how her learning was constrained:

“I was in year one, they wouldn’t facilitate any further learning because they said there is no need to push you any further because you have reached your goals.”  
Susan (Time 2 Year 2 Castleton University)

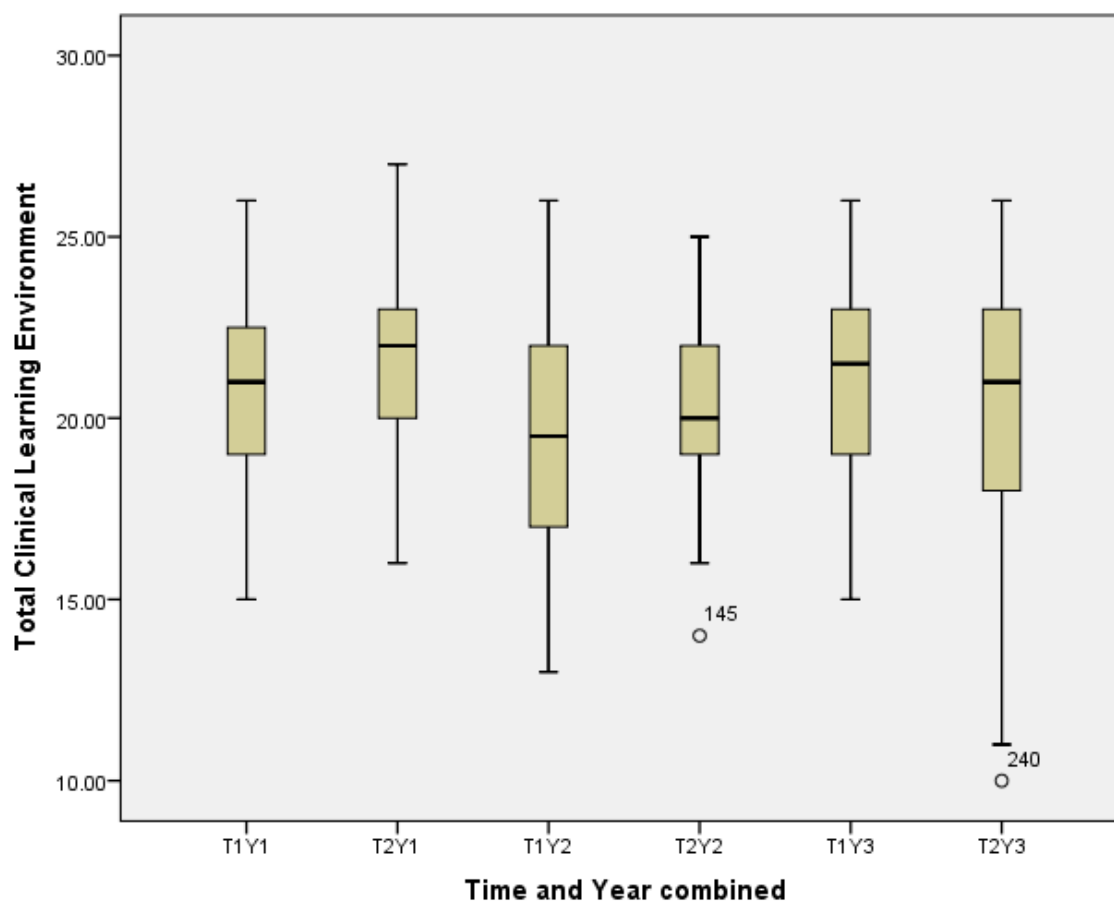
The interview data shows that students with prior HCA experience, perhaps more often than other students, can be used as a pair of hands in clinical practice in spite of their supernumerary status. The staff who support former HCAs’ development in clinical practice were perceived as important, and across time and year groups, none the more so than mentors. Positive support and attitudes by mentors were noted as important to help former HCAs develop confidence in their student role. Mentors also helped students to develop understanding of the boundaries of the student role, and facilitated movement away from task orientation to a broader understanding of nursing practice and skills. The impact of staff support was also sought in the survey.

### ***Support for learning: quantitative findings***

Section B of the questionnaire contained a nine-item scale adapted from Saarikoski *et al.* (2008) (Cronbach’s alpha =0.749) which asked students about their experiences in the clinical learning environment (CLE): “Looking back over your placements (practice learning experience) during the programme, how often did you experience ...?” (see Appendices 4.1 and 4.2). Students were asked to rate their experiences of support by mentors, supervisors, managers, lecturers, tutors and peers (Figure 5.5).

The interquartile range (range 9–27) shows that for each time and year group the median values of perceived levels of support are high with little variation across time and year groups: 21.00; 22.00; 19.50; 20.00; 21.50; 21.50. However, in the lower quartile at Time 2 Year 3 the lowest scores are recorded across all year groups, and for one student the score was particularly low. Nevertheless, Figure 5.5 indicates that across a range of learning supervisors, on a possible score range of 9–27, median scores of support levels were high across time and year groups. Mean scores were high and demonstrate little variation in scores: 20.77 (SD 2.84); 21.62 (SD

2.53; 19.43 (SD 3.03); 20.27 (SD 2.57); 21.03 (SD 2.92); 20.66 (SD 3.66). The standard deviation is greater at Time 2 Year 3 and is reflected in the lower quartile median scores.



**Figure 5.5 Clinical learning environment**

Individual items in the CLE scale were also analysed for combined time and year groups responses:

Item 1 on the CLE scale shows that 60.9% of students (n=181) indicated that they always experienced a positive attitude by mentors/supervisors, while 36.4% (n=108) stated that they sometimes experienced positive attitudes, and 2.4% (n=7) stated they that never experienced it. Nonetheless, over one-third of students perceived that they only sometimes experienced a positive attitude from mentors.

When asked if experiences of supervision were based on relationships of equality and promoted learning (Question 16, item 2), over half of students (55.9%, n=166) reported that this was always the case, 40.7% (n=121) that it was sometimes the case and 3% (n=9) that it was never the case.

Item 4 question 16 asked students to rate how often they were used as an HCA at the expense of their student role: “never”; “sometimes”; “always”. Responses indicated that 71.7% (n=213) of students were sometimes used as an HCA, but 60 students (20.2%) stated that this never happened and a small number (n=23; 7.7%) said that it was always the case.

Item 6 question 16 asked if managers had a positive attitude and promoted learning: 50.5% of students (n=150) reported that this was always the case, and 42.4% (n=126) reported that it sometimes the case. However, 20 students (6.7%) reported never encountering a positive attitude to their learning.

Willingness to discuss HCA work with students was the focus of three items (7, 8 and 9) in the CLE scale (Table 5.5).

**Table 5.5 Frequency of prior experience discussions with mentors, tutors and peers (q16 items 7/8/9)**

	<b>Never n (%)</b>	<b>Sometimes n (%)</b>	<b>Always n (%)</b>
I discussed my work as an HCA with mentors/ supervisors	46 (15.5)	161 (54.2)	89 (30.0)
I discussed my work as an HCA with lecturers/ tutors	69 (23.2)	168 (56.6)	59 (19.9)
I discussed my work as an HCA with fellow students	18 (6.1)	196 (66.0)	82 (27.6)

Total 296. Missing 1.

Table 5.5 shows that the largest group who never discuss HCA work with students are lecturers and tutors. Students’ peer groups are most likely to discuss HCA work, either always or sometimes. For all support groups the “sometimes” response is the most frequently stated option.

In summary, the quantitative data on support for learning indicates that students’ perceived staff support was high, with little variability evident between time and year groups. Individual items taken from the scale on the clinical learning environment indicated that almost 61% of students always experienced positive attitudes from mentors and supervisors and 56% recorded that

supervision was always based on equality and promoted learning. Just over 50% of students said managers always displayed positive attitudes and promoted learning, leaving 50% who did not. Seventy-two per cent of students said they were sometimes used as an HCA and the group of staff least likely to discuss students' former HCA experience were lecturers and tutors and those most likely were peers.

### **5.3.3 Theme 2 summary: The practice milieu**

The interview and survey data on transferring prior experience together provides complementary and contrasting views of students' clinical confidence. During interviews students explained that they perceived that prior experience did not prepare them for studentship as they had expected, particularly when placed in unfamiliar practice settings. This unpreparedness was felt most in Year 1 and students' confidence could be dented. However, the survey shows that in spite of this, students were confident in dealing with difficult situations across their entire studentship. Individual items also showed that students' range of clinical skills increased over studentship, though skills gained as an HCA decreased. Confidence in passing clinical assessments first time increased over time but even at the end of programmes one third of students were not confident.

The findings from interviews and the survey concerning staff support are largely corroborative. Interview data indicated the importance of the learning environment in facilitating or constraining students' progress. Across time and year groups the CLE scale shows that levels of support for learning were high, although at Time 2 Year 3 levels of support were perceived as low by 25% of students. The interview data also shows that across the years of study optimum support was not always forthcoming and demeaning acts and attitudes were displayed by mentors. Neither was prior HCA experience sufficiently acknowledged and built on. Supernumerary status was not always afforded, a finding corroborated in the survey where 72% of students recorded that they were sometimes used as an HCA. Interviews indicated that students perceived they were more likely than students without prior HCA to be assigned the HCA role. The interviews also indicated that students perceived that of all support roles, mentors who had positive attitudes were the most important to guide and support them. The survey data provides further insights and records that approximately 50% of students perceived that positive attitudes were not "always" present and, moreover, that almost half of managers did not "always" have a positive attitude and promote learning. The survey data also shows that across time and year groups the willingness to discuss

prior experience was most evident in peers and least in lecturers/tutors, a finding which did not emerge during interviews.

## **5.4 Summary**

This chapter presents the context and changing perceptions of students with prior HCA experience as they journey to registration as a nurse. The findings suggest that the transition from HCA to RN involves motivations, and challenges expectations. It involves changing perceptions of the nature of the HCA role and that of the RN. Students explained they had not understood the role of the RN. It was found that prior experience does not always stand students in the good stead they had expected and is not always easily transferable to students' clinical placements. Neither does it shield them from demeaning experiences. Students experienced strong mixed emotions across studentship. Findings also indicated that the mentor was the key person to facilitate the transition from HCA to student. Family, friends and peers as well as clinical staff who guided students' progress were also found to be important in guiding students' change and transition. Against this background, in the next chapter further thematic and statistical findings highlight the learning process of how former HCAs take up the role of student in preparation for life as an RN.

## **Chapter 6 Findings II: Becoming a student nurse**

### **6.1 Introduction**

This chapter presents the findings and final three themes which develop understanding of the work role transition from HCA to RN. As in Chapter 5 (Findings I), short summaries of the qualitative and quantitative subthemes are presented then combined in a final summary presented at the end of each theme, and the qualitative and quantitative data are compared and contrasted.

Section 6.2 presents Theme 3 “Embracing the clinical role”, which explains how former HCAs learn to be a student nurse in clinical practice, including the impact of their prior experience on their new role. Section 6.3 presents Theme 4 “The academic role”, and explains how former HCAs learn to be a university student. The final theme “Becoming a professional” presents in Section 6.4 the findings which indicate that students change not just clinically and academically but also personally as they strive to become an RN. Section 6.5 summarises the findings from this chapter and draws it together with the findings from the preceding chapter.

### **6.2 Theme 3: Embracing the clinical role**

This theme is concerned with how former HCAs take up the student role, how they come to see it, its impact on them and what helps and what doesn't help them to move away from the HCA role.

#### **6.2.1 Learning to be a student nurse**

Learning to be a student nurse involves developing confidence in oneself and one's abilities, and developing an increased knowledge base to enhance performance in clinical practice. The challenge for HCAs is to move away from a support role and develop a competent and confident performance befitting the role of student nurse.

#### ***Learning to be a student nurse: qualitative findings***

Anna, a first-year student with just six months' experience as a student nurse, articulates the differences between the HCA and student roles. She talks of trying to move away from a task and time orientation to one which involves a different performance:

“Although I don’t have the responsibility as such as the nurse but as a student I’ve got my thinking hat on and I’m looking at obs and I’m looking at I’m sort of looking at them generally skin, are they happy, are they in pain and I’m constantly thinking, But when I’ve got my HCA hat on I’m more task orientated.”  
Anna (Time 1 Year 1 Castleton University)

Anna’s comment reflects students’ realisation that the student role is one of constantly thinking about the “what” and “why” and not just the “how” of nursing practice.

An important ingredient for demonstrating the potential to become an RN is to project confidence inwardly as well as outwardly for others to see:

“...you want [to be] confident in yourself in front of all these qualified people who knows.”  
Simone (Time 1 Year 3 Castleton University)

Third-year students are able to look back at the changes they have experienced:

“I think looking back your knowledge base is still quite small really in your first year. Even though you have learnt a lot you still don’t know very much [...] by the time you get to the end of the first year and you are going back there you have got a lot more confidence.”  
Moyra (Time 1 Year 3 Castleton University)

Similarly, students report that practitioners see changes in their confidence:

Dora	Oh yeah my mentor has said she um I am told last time I worked with her she said she couldn’t believe the change in me you know.”
Interviewer	“Really? And did she say what those changes were?”
Dora	“Um she said my confidence has really, really grown like I said I did not have very much confidence to begin with and she said I can’t believe the confidence in you. You have shown me that you know what you are talking about.”

Dora (Time 1 Year 3 Lombard University)

Learning to be a student also required students to increase their knowledge base. Students had to develop skills of managing their learning while they were in practice and develop strategies to do so. Increasing confidence plays its part here too.

#### *Developing a knowledge base*

Knowledge can be attained in practice settings through interrogating knowledgeable practitioners. This requires students to move from a passive support role to an active and independent learning role. They must display behaviours relevant to the student role to convince mentors and registrants of their student role. This included being a proactive learner, a necessary prerequisite for gaining knowledge for practice. As students identified in Theme 1, the HCA role is perceived

as lacking underpinning knowledge and the student role is seen as one of thinking and acquiring knowledge. To acquire that knowledge, and link practice to theory, the behaviours and tasks of RNs must be identified and strategies for learning developed and managed. Students across year groups and universities identified that a key strategy for managing learning was becoming assertive and proactive, demanding learning even in busy placements. It was of importance if the HCA role was not to be perpetuated:

“If you are not very assertive person you sort of fall into the background ... You tend to get forgotten about. You end up doing just care assistant jobs. You won't actually learn ... I am quite assertive when I am on the wards. If I want to learn something I will find opportunities, but that's, even that's hard when they're busy and there is no one on and even your mentor is too busy.”

Terry (Time 1 Year 3 Castleton University)

Becoming confident enough to be sufficiently assertive and independent can be a difficult lesson to learn and can involve conflict:

“My mentor was the ward sister [...] and had the audacity to tell me that I needed to speak up more and facilitate my own learning more. And even though about a week before we sat down and had a bit of a confrontation about how that wasn't possible for me and she said well on this ward what do you expect? But since then I have made sure that I am not just pushed aside as an HCA.”

Susan (Time 2 Year 2 Castleton University)

To facilitate the move away from the HCA role students feel it important to question and observe RNs:

“Ultimately that's what you are aiming to do so you know observing and participating with them is the best way I think.”

Moyra (Time1 Year 3 Castleton University)

Dora demonstrates she has learned the importance of questioning practice and practitioners. Importantly, she is able to demonstrate her ability to perform this aspect of learning, despite her inner feelings:

“It took me quite a long time to pull myself out of my shell and start asking questions you know and when I did I found the difference huge you know....”

Dora (Time 1 Year 3 Lombard University)

Once students are sufficiently confident to be assertive and independent they are able to negotiate a variety of learning opportunities which help them to understand patient care and patient journeys. In addition to their placements, the experiences that students commonly requested included following patients and spending time with Clinical Nurse Specialists. These



opportunities enabled students to see health care practice more widely and develop their knowledge base:

“I went to cystoscopy, endoscopy, into outpatients, stoma care um worked with tissue viability, everything that I could grab, I grabbed.”

Carol (Time 2 Year 3 Lombard University)

Aside from making demands of practice organisations and of practitioners, students also developed a variety of techniques over their studentship to facilitate linking practice to theory. Of foremost importance was reading, which included a range of books and journals, acquiring information on the internet, and induction packs provided by practice settings. Other materials available in practice settings were also read and included material in small libraries located in practice settings, larger Trust libraries, policy documents, wall posters and notices. Throughout the years of studentship, reading played an important part in developing underpinning knowledge for practice and marked out increasingly independent learning:

“I am quite independent in my learning. I like to read myself. That saved me without really having to rely on lectures. [...] I think that helps me with my knowledge base and I would never rely on the wards to increase my knowledge. It's been good sometimes in the practical application of something, but on the whole my knowledge base has come from my own reading.”

Terry (Time 1 Year 3 Castleton University)

Students used their portfolio and practice skills logs to identify learning opportunities. The satisfactory completion of both documents was a prerequisite for successful progression through programmes of preparation. Sharon explained how mentors can facilitate learning by providing a continuum of support for students as the programme progresses. Her view reinforces the importance of mentors taking account of prior experience, which was identified in Theme 2 “The practice milieu”:

“Erm usually, it changes throughout the years so in year one it is a little bit more of a cotton wool so they would take you and have a chat with you with your mentor and have and find out what has happened on that ward or whichever area that you are working in and then you can decide what you would like to learn and what is beneficial to you and the learning opportunities in that area and also what I used to do was go through the skills log.”

Sharon (Time 2 Year 3 Castleton University)

In summary, the qualitative findings show that learning to be a student nurse required former HCAs to move away from a task and time orientation. They increasingly developed confidence to question practice and convince themselves and others that they had taken up the student role – and could demonstrate the potential to move into the RN role. Former HCAs recognised the need to develop their knowledge base and that to do this required developing confidence to become an

assertive and independent learner. A range of strategies such as reading widely were employed, but students also learned to request practice learning experiences to increase their knowledge base.

### ***Learning to be a student nurse: quantitative findings***

In Chapter 5 the clinical learning environment (CLE) was described (see Figure 5.5). On a possible score range of 9–27 little variation was found in perceived support levels across the years of studentship. The interquartile range containing 50% of cases shows that the median values for each group are largely distributed around the score of 20.

To find out whether clinical and professional confidence was associated with the CLE a Generalised Linear Model (GLE) was fitted across time and year groups (Table 6.1).

**Table 6.1 Relationship between the clinical learning environment and clinical and professional confidence across cohorts**

<b>CLINICAL CONFIDENCE</b>						
Clinical learning environment	<b>T1 YEAR 1</b>	<b>T2 YEAR 1</b>	<b>T1 YEAR 2</b>	<b>T2 YEAR 2</b>	<b>T1 YEAR 3</b>	<b>T2 YEAR3</b>
"F" ratio	.127	2.246	1.661	1.092	.988	1.243
df	2,41	2,34	2,42	2,34	2,66	2,59
Sig. (p value)	.881	.121	.202	.347	.378	.296
<b>PROFESSIONAL CONFIDENCE</b>						
Clinical learning environment	<b>T1 YEAR 1</b>	<b>T2 YEAR 1</b>	<b>T1 YEAR 2</b>	<b>T2 YEAR 2</b>	<b>T1 YEAR 3</b>	<b>T2 YEAR3</b>
"F" ratio	.415	1.483	1.021	1.011	1.373	.781
df	2,41	2,34	2,43	2,34	2,67	2,59
Sig. (p value)	.663	.241	.369	.374	.260	.463

For both clinical and professional confidence Levene's test was not violated (contravened) and, in summary, GLE testing showed no statistically significant relationship between the CLE and professional and clinical confidence in any cohort at any time point.

### **6.2.2 The impact of HCA experience on embracing the clinical role**

Prior experience as an HCA carries with it consequences which impact on students' transitions: expectations by staff of former HCAs; fear of bad habits acquired as an HCA; sliding back into the HCA role; continuing to work as an HCA.

#### ***The impact of HCA experience: qualitative findings***

##### *Expectations by staff of former HCAs*

It has long been held that people tend to live up to the expectations of those with whom they are interacting and develop a self-image that reflects that which others have of them (Merton 1957). Former HCAs needed to convince clinical staff to view them as students, but they also needed to convince themselves and leave behind their former support role and move to a student role. Veronica describes the HCA role as a hiding place which she had to fight to leave behind:

"Nobody could seem to see you in another role (student nurse). And you couldn't see your way of getting out of it because you are hiding there. It's sort of like a fight and it was really hard..."  
Veronica (Time 2 Year 2 Lombard University)

Students feared, whether or not justifiably, that as former HCAs they would remain pigeon-holed in the HCA role. This can be a particular concern for students who regularly return to the "home" base where they worked and continue to work as an HCA. Expectations can also create a dilemma for students entering new placements – whether they should to reveal their past experience and have it recognised or run the risk of being seen, and possibly judged, differently to other students.

"Initially with them I think I told them straight away because I think at the beginning of my training I wanted them to see that I had this ability... I wanted them to realise that I had a bit more experience. You know ... but funnily enough since then I mean that the ward that I am on now I haven't told them. And I think the reason is the minute you tell them they seem to expect [...] if I don't understand something I find that I am looked at differently and ... they look at you as if you should know that as an HCA. So it makes me feel as though I would rather not tell them ... and why should I be judged differently from someone else who hasn't got HCA experience ... I don't want people to think that because I was an HCA that you know that's all that I can do. I'm just good for bringing a commode to a patient, or making a bed. Do you know what I mean? I want to be able to progress."  
Brenda (Time 2 Year 1 Castleton University)

Even if students decide not to reveal that they have prior HCA experience, it can be hard to hide it from staff:

Interviewer                      "Is it obvious when you have been on wards?"

Brenda “Yeah they [students with prior experience] because they know how to treat patients don’t they. They know how to do all the erm, all their care. They know how to move a patient and how to wash a patient, er whereas if you’ve never done that you don’t know how to do it.”

Brenda (Time 2 Year 1 Castleton University)

Prior experience, if relevant, can show through not only in the ability to complete tasks competently but also to confidently communicate with patients. This was seen as a key advantage of prior experience across the year groups:

“... um yeah and their confidence as well. You can see if they have had that past experience of being with people it comes across. If they haven’t had the experience dealing with people you see they don’t seem to have that sense of um ... empathy, they don’t seem to connect.”

Veronica (Time 2 Year 2 Lombard University)

However, even though former HCAs felt confident in approaching patients once a student nurse, the manner in which they formerly did so was called into question and deemed inappropriate:

“... we used to say oh darlin’ blahdy blarhdy blah like that [speaking loudly]. Now you know that you shouldn’t really say that you know you always address a patient and ask them how they would like to be addressed you know I think about how to speak to somebody is how to get down to somebody’s level whereas before you would walk in and say oh you know hello [loud and nonchalant] ... I just feel totally different when I approach them. I think I have more knowledge and I know how I should be approaching them.”

Janet (Time 2 Year 1 Lombard University)

Learning the manner and demeanour of the nurse as exemplified in Janet’s explanation of the difference between the HCA and RN approach required students to unlearn prior practice and learn new ways of being. It also caused them to question the execution of other clinical skills they had acquired as an HCA. They were concerned they had been taught skills “incorrectly” in former workplaces:

“I don’t like people who say to me you know how to do it. If I was an HCA I would go on my own and I would do it but as a student you have to come with me and you have to assess what I am doing because I might, don’t do things properly. So I am really conscious about that really.”

Steve (Time 1 Year 1 Lombard University)

### *Bad habits*

In addition, in their former role some have seen poor practice. Some students recognise they have acquired bad habits:

“You [as an HCA] have bad habits – you never have to upgrade.”

Sally (Time 2 Year 2 Castleton University)

Ironically, prior experience of poor practice can act as a foil for recognising good practice:

"The nurses were lazy and attitudes to residents was poor um and looking back now and I've been out on practice and seen now how nursing should be what I saw was actually poor."

Annaya (Time 2 Year 1 Castleton University)

### *Backsliding*

A further constraining consequence of HCA experience is the temptation as a student to slide back into the HCA role. Above in Theme 2 "The practice milieu" students talked of being involuntarily used as HCAs. However, the data also indicates that students revert back to the HCA role voluntarily. It is a role they feel comfortable in, and are at one with. Sliding back occurs particularly in Year 1 students and when the student placement is similar to or the same as their prior HCA workplace:

Interviewer "And did you find yourself sliding back during that first year?"

Vicky "Yes a lot because it's as I say it's a comfort zone, you go back to what you know."

Vicky (Time 1 Year 2 Lombard University)

However, students can revert back to the HCA role right up to the end of the programme:

"Oh yes oh yes right up to the last placement."

Tanya (Time 2 Year 3 Lombard University)

It was found that there are a variety of reasons students slide back into the role, not just that it feels natural and comfortable. Across universities and year groups students talk of sliding back when the practice setting is very busy and as experienced workers they can see that patients' care needs are not being met. This creates a dilemma for students who must decide whose needs should take precedence: their own learning needs or patients' needs:

"I did find myself a few times "Do you want to go down and see a scan...?" and out the corner of my eye I can see somebody needs something and I'm saying "Hang on just let me do this first..." "If you want to go and watch, go now" and that patient I know wants a commode and I really want to go and see that and I do find myself torn quite often."

Anna (Time 1 Year 1 Castleton University)

It can also be frustrating for students whose prior experience enables them to see when staffing problems arise and how reverting to the HCA role will ease them:

"...that sense of frustration, you can see that ward is really busy you can see that it has come to a standstill, you can see those problems and sometimes it is just easier to go back into my HCA role."

Veronica (Time 2 Year 2 Lombard University)

Students not only slide back when there is a problematic shift but also when they are tired of having to think:

“Sometimes yes [laughs]. If it’s a bad shift or if I am particularly tired I can go into autopilot and just do all of that and not have to really think, which I would never say to an HCA.”

Susan (Time 2 Year 2 Castleton University)

The attitudes of staff can also encourage sliding back. Students talk of sliding back into the role to look busy and get the work done:

Terry “So there is that kind of feeling even now especially on certain placements even though you are supernumerary you’re seen reading or something, that you are being lazy and not getting on with things to do. And I think again that affects you.”

Interviewer “Does that mean that you sometimes fall back into being an HCA?”

Terry “Yes definitely, yes.”

Terry (Time 1 Year 3 Castleton University)

Furthermore, students are encouraged to slide back by staff who approve when they revert to the HCA role:

“Oh yeah because and then the other HCAs think that you are great and they are nice to you and you stay away from the staff nurses so you are not getting any grief so they are happy with you as well. That would definitely be the most difficult thing.”

Tanya (Time 2 Year 2 Lombard University)

However, mentors can play a key role by reminding students when they are sliding back into the HCA role. The following quotation shows how mentors, by taking account of prior experience, can support students stepping into the new role:

“If they needed feeding and I did sometimes slide back there. The good thing was that I had such a fabulous mentor who would say ‘J come back here’ and she would laugh about it. It wasn’t that I was nervous about being a nurse, it was just a natural thing to be an HCA again.”

Jill (Time 1 Year 1 Lombard University)

### *Wearing two hats*

Students move between different rights and duties when they move between paid HCA work and student roles. Patients and staff can be confused about which role the individual is performing on any given day and what that role entitles them to do. This is a more prominent problem for students at Lombard University since they were part-time seconded students who over and above the 26 hours per week allocated to studentship, returned to the workplace as an HCA. Moreover, many returned to the setting which is used as a home base when a student. This results in confusion:

“People don’t see that there are boundaries there they just see you.”

Veronica (Time 2 Year 2 Lombard University)

However, students in all cohorts and from both universities report how they manage the situation and the tasks they may and may not perform:

“Yeah yeah you have to get your head together before going on a shift otherwise you can end up making a fool of yourself and in front of other people because they can ask you to do something and you are not actually allowed to do this because there are some things that you can do as an HC that you can’t do as a student and vice versa. So you just need to think a bit and also if you go to do something in a general run around the ward and people working don’t know you are a student nurse, I had one recently in year two um you will get some funny looks and they think you are sort of being over-confident.”

Susan (Time 2 Year 2 Castleton University)

Staff expect particular behaviours from HCAs and the confident behaviour Susan alludes to is deemed more appropriate for a student than an HCA. However, from early on in the programmes all student cohorts indicated that they could not leave behind the student role when working as an HCA. The role of student became increasingly embedded and when working as an HCA students reported thinking and behaving like a student. It seems they cannot divest themselves of the student role. In Years 1 and 2 students described how they take the techniques learnt as a student to facilitate their progress, such as observing and questioning registrants, and continue to think and act like a student when working as an HCA:

“I don’t know as a Health Care I am always thinking as a student nurse even though I have separate uniforms on and I go in as a Health Care and put my comfy slippers on and know what I am doing I am still questioning and watching and taking it that bit further now like I would as a student nurse. The only thing is that I can’t give medication as a Health Care and I’ve got to keep remembering that.”

Jill (Time 1 Year 1 Lombard University)

By the end of Year 2 and in Year 3 they describe how knowledge gained as a student cannot be left behind and they draw on that knowledge when working as an HCA:

“I go to work as an HCA but I work as a knowledgeable HCA – you know that does everything needs to do but does them with the knowledge behind. Actually it is possible even though HCA.”

Marcus (Time 2 Year 3 Castleton University)

Because they maintain the student role, working as an HCA provides the opportunity to gain more nursing knowledge:

“The hospice I think the care of patients in the hospice is amazing the main thing and you feel satisfied that every patient is clean and comfortable. I can definitely see that. I can take that to the hospital.”

Joan (Time 2 Year 1 Castleton University)

Interestingly, one student gave up being an HCA in her third year because she felt it constrained her progress:

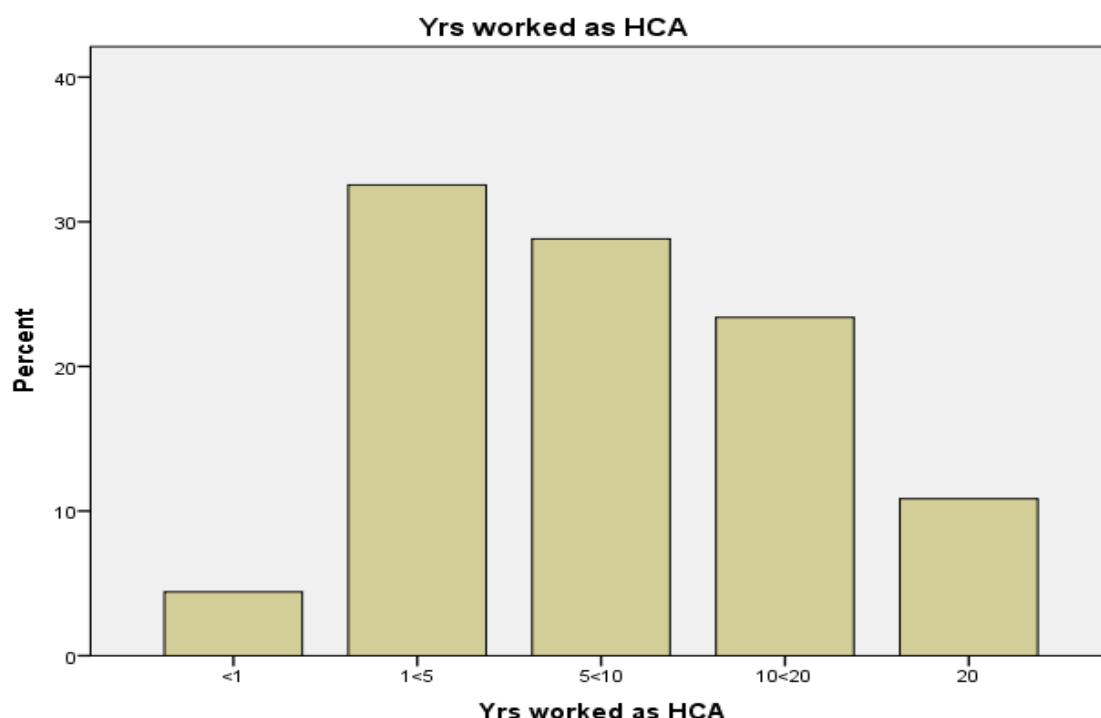
“I don’t think I would have got through the third year if I had kept working ... um as I stated before because I enjoy it so much and because I enjoy people it is very, I can get very absorbed in being an HCA and then I find it difficult to move on.”  
Sharon (Time 2 Year 3 Castleton University)

In summary, the qualitative findings indicate the impact of former HCA experience reaches into studentship with consequences for learning. Students reported that staff expectations of them could be different from those of other students and the question arose “to tell or not to tell?” Prior experience also resulted in students feeling concerned that they had been taught incorrectly and/or had acquired bad practice. However, they reported that, particularly early on in programmes, they were confident in approaching patients, but the manner in which they did so became to be seen as no longer appropriate. It was also found that students can slide back voluntarily into the HCA role when tired and overwhelmed. But they also slid back when the clinical areas were busy and working as an HCA relieved the situation. This created dilemmas for students, who found they might need to choose between their own learning needs and the needs of patients. Former HCAs also reported that staff could encourage retreat to the HCA role. However, it was also noted that appropriate guidance from mentors can support students to move away from their old role and into the new one. Further, continuing paid HCA work was found to be unproblematic by students, even if confusing for staff and patients. Students quickly see and respect the boundaries of the roles and as studentship progresses use their HCA work to inform their studentship. They found they could not divest themselves of the student role.

### ***The impact of HCA experience: quantitative findings***

The interviews indicated that staff expectations are mediated by students’ former HCA role. The questionnaire shows the number of years students spent as an HCA split into quintiles, combining the cohorts data from all six time points (Figure 6.1).

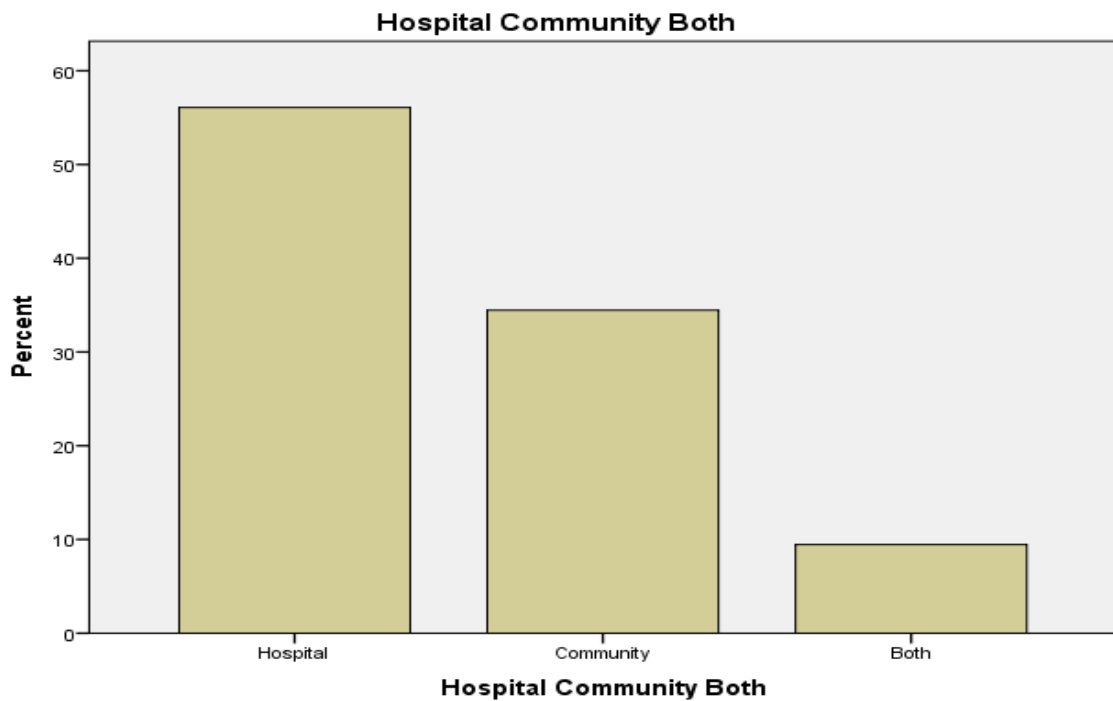




**Figure 6.1 Years worked as an HCA: percentages in quintiles, cohorts combined**

Data were missing from two students but Figure 6.1 shows that the greatest percentage of students had worked for between one and for less than five years (32%, n=96) as an HCA, followed by those who had worked between five and less than ten years (29% n=85). Students who had worked for ten and less than 20 years accounted for 23% of the sample (n=69). However, 11% (n=32) of students had worked more than 20 years as an HCA while only 4% (n=13) had less than one year's experience but more than six months'. The data shows that 63% of students had spent five or more years as an HCA, a substantial amount of time to become accustomed to the role, and with it the expectations of self and others.

Students had gathered experience as an HCA from a wide variety of practice backgrounds where they may or may not have been taught "correctly". Figure 6.2 gives an overview of the practice settings where former HCAs worked.



**Figure 6.2 Former workplaces: percentages of students, cohorts combined**

As noted in Chapter 5, the data on former workplace settings is somewhat arbitrary given the current diverse nature of health care provision and the overlap which exists across the traditional hospital and community divide. However, students were able to locate their former workplace in one or other area and in a small number of instances (n=28, 9.5%) opted for identifying their experience in both. Datum is missing from one student but Figure 6.2 shows that 56% of students (n=166) were formerly employed in a hospital setting and 34.5% (n=102) in a community setting.

Foreseen and unforeseen consequences can occur when the HCA role continues throughout studentship. “Which hat today?” is the question asked of students by mentors, other staff, patients and students themselves when working as an HCA. Table 6.2 outlines the numbers of students and hours worked as HCAs during studentship. It shows that out of a total of 297 students over 77% worked as HCAs during studentship and just over 30% worked more than 45 hours per month.

**Table 6.2 Working as an HCA during the programme, cohorts combined**

<b>Working as an HCA during the programme</b>	<b>Hours worked per month n (%)</b>
0 hours	68 (22.8)
<15	48 (16.2)
>15–30	52 (17.5)
>30–45	38 (12.8)
>45–60	48 (16.2)
>60	43 (14.5)
Total working students	229 (77.2)
Missing	0

In addition, as more than 20% of the sample responded to the question (21) “What are your reasons for working as an HCA during the programme?”, the data for this open question was analysed. The most frequently cited reason was being seconded by an employer and contracted to work HCA hours in addition to student hours (n=129). These responses were all from students at Lombard University whose programme is part time and aimed at seconded students. The second most cited reason for continuing to work as an HCA was financial (n=71). However, 20 students stated both reasons, contractual and financial, for continuing to work as an HCA. Moreover, ten students cited keeping up skills as a reason to continue working as an HCA, eight to improve their knowledge and five to alleviate staff shortages in their former HCA workplace.

The need to think and be alert about each role and what it entails is also reflected in the survey responses. Question 20 asked about the impact of working as an HCA during the pre-registration programme and item 1 asked how that impacted on adjusting to their student role (Table 6.3).

**Table 6.3 The impact of working as an HCA during the pre-registration programme (1)**

“I find it difficult to adjust to being a student nurse in clinical practice.”

	T1 Y1 n (%)	T2 Y1 n (%)	T1 Y2 n (%)	T2 Y2 n (%)	T1 Y3 n (%)	T2 Y3 n (%)
Always	2 (6.9)	1 (3.7)	4 (10.0)	1 (3.6)	6 (10.2)	3 (5.8)
Sometimes	19 (65.5)	10 (37.0)	37 (42.5)	16 (57.1)	39 (66.1)	25 (48.1)
Never	8 (27.6)	16 (59.3)	19 (47.5)	11 (29.7)	14 (23.7)	24 (38.7)
Missing	15 (34.1)	11 (28.9)	6 (13.0)	9 (24.3)	11 (15.7)	10 (16.1)

Although Table 6.3 has missing data and results should be treated with caution, valid percentages are recorded (i.e. percentage of those who responded), which demonstrates that at the beginning of the programme greater numbers always or sometimes found it difficult to be clear about what was expected of them in clinical practice than at any other point in the programme. By the end of Year 1 and in Year 2 fewer students felt it always or sometimes difficult to be clear what was expected of them as a student. Nonetheless, by the beginning of Year 3 66% of students still sometimes felt it difficult, and at the end of programmes 48% of students still sometimes found it difficult to adjust.

The survey also asked students about the impact of working as an HCA during the programme on their clarity about their student role in clinical practice (see Table 6.4).

**Table 6.4 The impact of working as an HCA during the pre-registration programme (2)**

“I find it difficult to be clear about what is expected of me as a student nurse in clinical practice.”

	T1 Y1 n (%)	T2 Y1 n (%)	T1 Y2 n (%)	T2 Y2 n (%)	T1 Y3 n (%)	T2 Y3 n (%)
Always	3 (10.03)	1 (3.7)	2 (5.0)	2 (7.1)	3 (5.1)	3 (5.8)
Sometimes	16 (55.2)	7 (25.9)	15 (37.5)	12 (42.9)	43 (48.6)	16 (30.8)
Never	10 (22.7)	19 (70.4)	23 (57.5)	14 (37.8)	22 (31.4)	33 (63.5)
Missing	15 (34.1)	11 (28.9)	6 (13.0)	9 (24.3)	11 (15.7)	10 (16.1)

Table 6.4 has missing data and results should be treated with caution, but valid percentages are reported. The table demonstrates that at the start of programmes greater percentages of students always or sometimes found it difficult to be clear about what was expected of them in clinical practice and this was greater than at any other point in the programme (66%). However, by the end of Year 1 the figure had dropped to 30% and by the end of year three over 37% recorded this to be the case.

Students were also asked if working during the programme helped them as a student nurse (Table 6.5).

**Table 6.5 The impact of working as an HCA during the pre-registration programme (3)**

“My work experience as an HCA helps me as a student nurse in clinical practice.”

	T1 Y1 n (%)	T2 Y1 n (%)	T1 Y2 n (%)	T2 Y2 n (%)	T1 Y3 n (%)	T2 Y3 n (%)
Always	23 (79.3)	17 (63.0)	27 (58.7)	17 (60.7)	31 (44.3)	34 (65.4)
Sometimes	5 (17.2)	7 (25.9)	11 (27.5)	11 (39.3)	24 (40.7)	15 (28.5)
Never	1 (3.4)	3 (11.1)	2 (5.0)	–	4 (6.8)	3 (5.8)
Missing	15 (34.1)	11 (28.9)	6 (13.0)	9 (24.3)	11 (15.7)	10 (16.1)

Valid percentages are recorded and due to missing data, in part due to not all students working during programmes, the results should be treated with caution. However, the data demonstrates that the highest number of respondents who recorded that working as an HCA during the programme is always helpful is at the start of programmes. Thereafter the percentage falls, being lowest at the beginning of Year 3, but the percentage rate recovers to 65% at the end of programmes. The mean percentage across the time and year groups of it always helping is 62%.

The General Linear Model (GLM) was fitted to the data to find out if variations between groups were present in clinical and professional confidence measures and years worked as an HCA, former workplace, continuing to work as an HCA and also positive feelings, negative feelings and stress. Appendix 6.1 summarises the findings. In summary, GLM testing showed no statistically significant relationship at any time or year with the clinical confidence measure and years worked as an HCA, former workplace or continuing to work as an HCA. The independent variables, “negative feelings” and “stress”, showed their effects were statistically significant at Time 1 Year 1 (.018 and .044) and their effect large ( $n^2 = .426$  and  $.200$ ) (Cohen 1988). There was no violation of Levene’s test in the clinical confidence tests.

In addition, the GLM testing shows no statistically significant relationship at any time point in any cohort with professional confidence and years worked as an HCA or former workplace. Continuing to work as an HCA reached statistical significance at Time 1 Year 3 ( $F(4,53) = 4.002$ ,  $p = .007$ ), but Levene’s test was violated ( $p = .002$ ) so the result was disregarded. Levene’s test was not violated in all other tests on professional confidence. However, the independent variable “Feelings” showed that positive feelings reached statistical significance at the end of Year 1 ( $F$

(5,25)=2.777  $p=.040$ ) and at the end of year two ( $F(6,22)=4.509$   $p=.004$ ) (Appendix 6.1) and  $\eta^2$  (.357 and .551) indicated that the effect is large (Cohen 1988).

In summary, the quantitative findings have provided descriptive and inferential statistics on the impact of prior experience on embracing the clinical role. Sixty-three per cent of students had spent five or more years as an HCA and over half in hospital settings. Seventy-seven per cent did paid work as HCAs during studentship and of these, a mean of 62% found working during the programme was always helpful. Those who sometimes or always found it difficult to adjust to clinical practice as a result of working as an HCA during the programme was highest at the beginning of programmes and at the start of Year 3. By the end of programmes almost 54% of students still or always found adjustment difficult. In addition, GLM tests suggest that years worked as an HCA, former workplace and continuing to work as an HCA have no statistically significant effects on the clinical and professional confidence measures across cohorts and time points. However, negative feelings and stress were significant with respect to clinical confidence at the start of programmes and positive feelings at the end of Years 1 and 2 were significant with respect to professional confidence.

### **6.2.3 Theme 3 summary: Embracing the clinical role**

The qualitative and quantitative findings together paint a complementary picture of studentship. The qualitative data provides core understandings and the quantitative data not only provides specificity but also provided the possibility of tracking and testing change over time to illuminate the process of transition.

The qualitative data indicates that learning to be a student is concerned with developing confidence inwardly as well as outwardly for others to see. It is also concerned with developing a knowledge base for practice. A range of strategies were found during interviews which develop students' knowledge, but becoming an assertive and independent learner in the practice setting was found to be of importance. As noted in Chapter 5 (Figure 5.5), the quantitative data indicated that levels of CLE support were deemed high across programmes. However, GLM testing found no statistically significant relationship between the CLE and professional and clinical confidence measures across time and year groups.

The qualitative findings also indicate that the impact of prior HCA experience has consequences for learning to be a student. Expectations of students by staff can be high and different from those of other students. Former HCAs must decide whether to admit to prior experience or not. The quantitative data showed that 63% of students had worked for five or more years as an HCA and 11% for more than 20 years. Interviews found that students felt worried that they had been taught clinical skills incorrectly and/or acquired bad practice when an HCA. The survey data showed that 56% of students had formerly worked in hospital settings and 34% in community settings. However, GLM tests did not find statistical significance across any of the six time points with respect to the former workplace and clinical and professional confidence measures.

Qualitative findings indicated that students can slide back voluntarily into the HCA role when tired and overwhelmed. But they can also slide back when clinical areas are busy and staff request it. Prior experience creates dilemmas for students, who may need to choose between their own learning needs and the needs of patients. Students indicated that the guidance of mentors can support students' development away from their old role and into the new one, but GLM testing found no statistically significant relationship across the six time points in the CLE and professional and clinical confidence measures.

Further, interviews indicated that continuing to work as an HCA was found not to be problematic for students, even if confusing for staff and patients. The survey indicated that 77% of students did paid HCA work during the programmes and being under contract as a seconded student and earning money were the two most cited reasons. Just over 30% of students worked 45 hours or more per month. Across the time and year groups 62% (mean score) of students recorded that working during the programme was always helpful. By the end of programmes 54% of students recorded that they sometimes or always had difficulty adjusting to clinical practice having worked as an HCA during the programme. However, the interviews found that students were quick to see and respect the boundaries of the two roles and as studentship progressed they used their HCA work to inform their studentship. Students found they could not divest themselves of the student role. GLM tests did not find statistically significant relationships across cohort time points between working as an HCA during the programmes and clinical and professional confidence measures. However, negative feelings and stress did have significant ( $p=.018$  and  $p=.044$ ) and large effects at Time 1 Year 1 on clinical confidence ( $\eta^2=.426$  and  $.200$ ), and positive feelings had significant

large effects at the end of Year 1 and the end of Year 2 with respect to professional confidence ( $p=.040$  and  $p=.004$ ) and  $n^2$  (.357 and .551) indicated that the effect is large (Cohen 1988).

## 6.3 Theme 4: The academic role

The academic segment of studentship requires individuals to perform to prescribed standards and demonstrate intellectual competence. As in clinical practice former HCAs endeavour to convince themselves as well as others of the veracity of their performance. In the world of academia, competence is calculated in a series of tests ranging from Objective Structured Clinical Examination (OSCE) testing clinical performance to assignments to exams. Students must demonstrate progression through the various assessment elements and step up their performance through the levels of academic study.

### 6.3.1 Academic confidence

Academic study is seen as a means to an end, a gateway to step through before the real business of working as an RN can begin. However, progression is hard fought and hard won, and involves “a lot of blood, sweat and tears” (Janet, Time 1 Year 2 Lombard University).

#### ***Academic confidence: qualitative findings***

At the beginning of their studies former HCAs can lack confidence in their academic abilities. For example, Anna does not see herself as a scholar. She expresses a lack of confidence and sees her lack of prior education as constraining:

“Essay writing I’m useless and I’m 32 and I left school at 16 and I’ve come to university and I’ve never had to write an academic essay in my life and now I’m having to do it ... and this is only my first year and next year they are going to expect a lot more of me and I am not that confident that I am going to be able to get the grades and be able to continue with these grades.”

Anna (Time 1 Year 1 Castleton University)

Anna fears she will not cope academically and not be able to successfully complete the programme. However, students can tolerate rather than embrace the academic role, particularly in early parts of programmes:

“You know if I am honest I am not huge academic person anyway. I’m more of hands on learner, so I have to work really hard.”

Brenda (Time 1 Year 2 Castleton University)

Students accept that knowledge is needed to take up the student role:

“I do know that we do have to have theory to back up learning what we are.”

Jill (Time 1 Year 1 Lombard University)



The role of HCA is often linked to NVQ qualifications, which are essentially practice competencies-based learning activities which arguably do not encourage students to learn beyond the task in hand, or encourage independent learning. One hundred and eighty seven students out of 297 were recorded in this study as having vocational qualifications. Former HCAs can find themselves engaged in a struggle to step into the academic role of university student. One important skill which facilitates the move to student in higher education is becoming an independent learner. It is an issue felt most keenly in Year 2 of the programmes when the struggle to progress is intense:

"We're all feeling fed up with it and scared. We've got an assignment that's due in April and it's still not really been explained to us."  
Cath (Time 2 Year 2, Castleton University)

The struggle to progress and be confident academically is also evident in Lombard University students:

"I don't have much faith in myself it that makes sense I take exams and I panic I am going to fail ... and I have passed the last one, no I got through it by the skin of my teeth, but that is all I need."  
Amanda (Time 2 Year 2 Lombard University).

Even students with a strong record of good academic achievement need to adjust to nursing's academic style and requirements. For example, Terry, a third year student with a degree in English Literature, felt confident of his academic abilities from the outset. He nonetheless recognised a different style was needed to write nursing assignments:

"I had done a degree, I wasn't really, really, worried about the academic side of it, I think I was more worried about the practical side of it ... confident yes but it's a different style of assignments I think."  
Terry (Time 1 Year 3 Castleton University).

If students cannot perform to a minimum standard as prescribed by academic and professional institutions, then no matter how good their clinical performance, individuals are not deemed able to fulfil all the requirements of the RN role and cannot register as a nurse. This is a source of great worry and anxiety for former HCAs, particularly early in programmes. Former HCAs with no HE experience can also hold restricted views of what being a university student entails. This lack of perception echoes their restricted views of the RN role (Theme 3), and is in contrast to their mistaken belief that HCA experience would carry them through in clinical practice. Former HCAs' fears of university and academic failure was great:

"Terrified, absolutely terrified. I left school at 16 and then here I was 31 and going back to university and in my head it's a very young environment that I was going to be way

out of my comfort zone. There were people there and it leads to exams and essays that type of thing. The academic side absolutely petrified me. To the point, actually at one point I did think to myself, oh my God what have I done, I can't cope with this.”  
Annya (Time 1 Year 2 Castleton University).

Students fear they cannot cope with academic demands and, as with the clinical role, students must convince themselves and others of the veracity of their performance. Again confidence is a key issue: confidence that they are able to fulfil role requirements. By Year 2 confidence increases as assessments are successfully negotiated:

“The day I get my results it's like I have just done another GCSE, or you know a major exam, because it really does boost your confidence.”  
May (Time 1 Year 2 Lombard University).

By Year 3 confidence and competence have increased further as students more fully embrace the academic role, as Tina's statement reflects:

“I just giggle at the fact the first couple of essays that I wrote, they were so terrible. You don't think you will ever be able to write like an academic but you do grow and you do learn to write valid material and stuff that will be respected by your colleagues.”  
Tina (Time 1 Year 3 Lombard University)

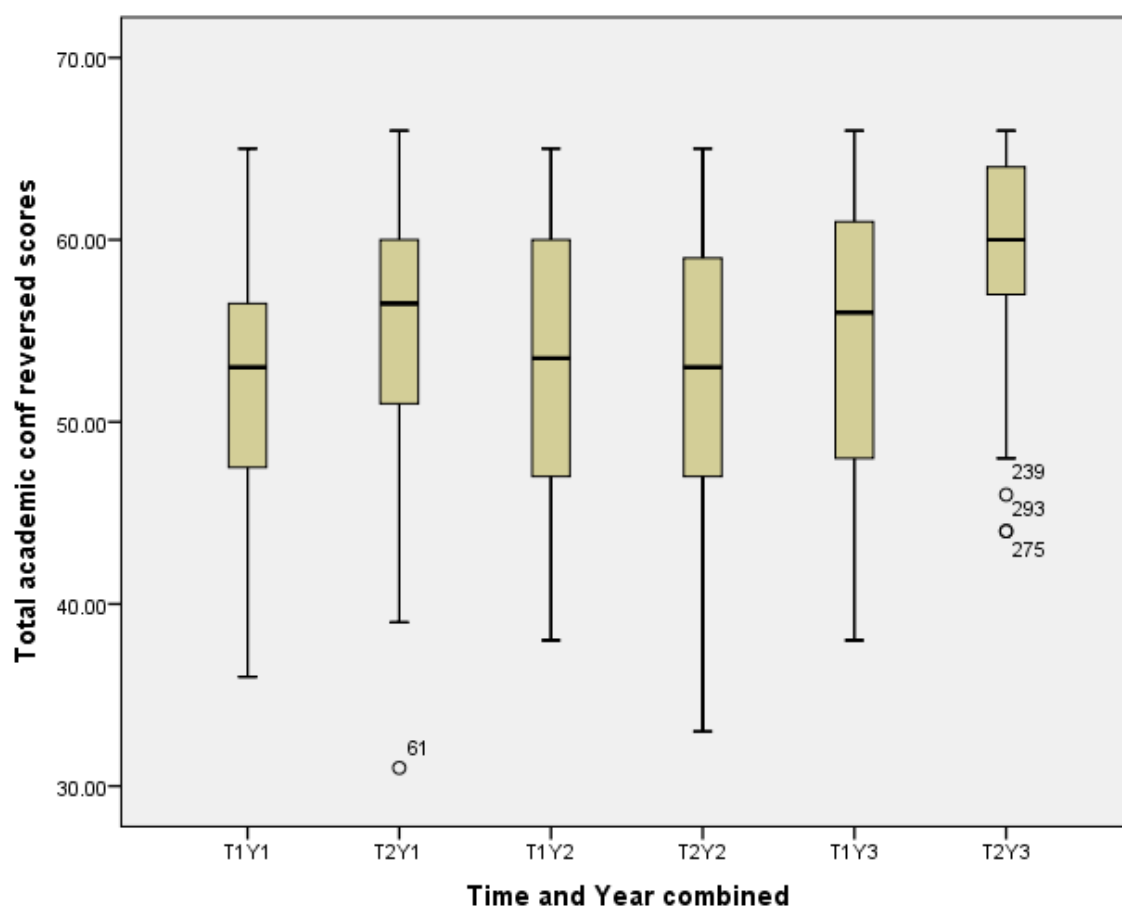
Moreover, students can eventually embrace the role, despite its challenges:

“I'm missing it a wee bit and I think if I got into a specialty or something I would want to learn more. But of course if you had asked me six months ago it would have been no way, yes.”  
Tanya (Time 2 Year 3 Lombard University)

In summary, the qualitative data findings show that academic confidence develops over time. Students' prior academic or vocational qualifications may be insufficient to engender confidence at the outset of studies, but as academic tests are successfully negotiated confidence increases.

### ***Academic confidence: quantitative finding***

Former HCAs come to pre-registration programmes with a range of academic qualifications. Although all students must meet the minimum academic qualifications demanded by the NMC and HEIs, as noted in Chapter 5 (Table 5.2), 113 out of 297 students in this study hold “A” level or equivalent qualifications and 18 students hold a first degree or postgraduate qualification. Academic track records can impact on former HCAs' confidence to achieve the required standards. In Section C of the survey students were asked how confident they were about their academic skills (Figure 6.3).



**Figure 6.3 Academic confidence across cohorts**

On a possible score range of 22–66 the median scores indicated that the highest score was at the end of programmes and the lowest at the beginning: 53.00 (SD7.26); 56.5 (SD 7.50); 53.50 (SD7.42); 53.00 (SD7.35); 56.00 (SD7.51); 60 (SD 5.55). Low scores were also recorded in at the end of Year 2. At the end of Year 2 median scores were almost as low as at the start, and the lowest quartile scores are found at this time point. In addition, the standard deviation was lower at Time 2 Year 3 than at other points. The mean scores reflect these findings. The six mean scores over the time and year points were: 52.25; 55.31; 52.86; 52.86; 54.73; 59.80.

In summary, the quantitative findings suggest that academic confidence is highest at the end of the programmes and lowest at the beginning, but at the end of Year 2 confidence is also low.

### 6.3.2 Developing academic skills and understanding

As noted above in Theme 3 “Embracing the clinical role,” a hallmark of studentship and one that separates it from the HCA role is developing a knowledge base for practice. However, the ability

to see the relevance of theory to practice performance, particularly early in the programme, can be a challenge.

### ***Developing academic skills: qualitative findings***

Students may see the relevance and application of biology to clinical practice but struggle to apply psychology and sociology to patient care:

“I don’t seem to get on very well with the sociology, I just even now I just think other than the basics why do I need to listen to this? And I struggle with that and the psychology ... and the health promotion and looking at health in different way and the biology obviously that’s great. But sociology, lovely teacher, just don’t get the subject.”  
Anna (Time 1 Year 1 Castleton University)

However, by Year 3 the relevance and application of theory taught in the universities is much clearer to students:

“... now that I’m in my third year I have a better understanding. In the first year you’ve got more of a “I don’t know what I’m learning”, I do know why I am learning this but I don’t know how this is applying. Whereas by the time you get to your third year because you are getting more used to social policy and how that impacts on health, like for example legislation and National Service Frameworks and NICE guidelines and how that is affecting your practice I think you have a better idea of how that applies.”  
Moyra (Time 1 Year 3 Lombard University).

Assignments of all kinds, including those of a theoretical nature and not just case studies, are deemed helpful and facilitate application of theory to practice and practice to theory.

“... so the assignment that I am in at the minute, that I am in at the moment is about reductionism and holism and it is only as you are reading it that you thought you sort of like see it and think about it. And being on oncology of course you think to yourself it’s around you all the time but you are blind you can’t see it... Reading the book you think to yourself oh yeah and yes OK I understand that now OK I see what they are getting at.”  
Vicky (Time 1 Year 2 Lombard University)

When learning to perform academically students develop a range of strategies and skills to facilitate learning. As in clinical practice they learn to access a range of resources including academic staff such as librarians, but principally lecturers. Family and friends can also help but staff in clinical practice generally do not help, aside from providing specific practice knowledge. Students also develop ways of managing their studies, such as better time management. As in clinical practice students learn to utilise resources such as books, journals and the internet. Reading and thinking are identified as key strategies for improving performance, particularly for assignments. By Year 3 students across universities indicate that they have developed skills to support effective learning:

“Well normally I try to plan it properly I don’t leave it until the last minute, I was in plastics, I pick up the things I need from textbooks and then go look on databases, I look for journals that are relevant and weed out the ones that are not relevant enough and then I put that onto my pen drive things that I need and from that I look for articles, yes.”

Terry (Time 1 Year 3 Castleton University)

As the quotations in this theme suggest, there is a remarkable synergy between year groups and universities in students’ perceptions of their academic journey. However, one major difference exists between students at the two universities. It is not concerned with individual performance but instead is closely bound to the organisations who deliver the programmes. The academic teaching for students at Lombard University was delivered primarily through distance learning while those at Castleton University were taught more traditionally through face-to-face tuition. At Lombard University teaching was primarily provided through specially prepared course materials, although some face-to-face tuition was also provided. In contrast, students at Castleton were principally taught in two geographical locations and teaching was provided through lectures and some tutorials. For students at Lombard, distance learning presented some challenges. Students have to maintain motivation and focus when families also create demands:

“I’m finding it hard that it’s home study because you still have like the dusting and finding time to do the study and when you are telling the family when you are studying they still come in and have like an hour’s conversation. That’s hard to say that you can’t disturb me. I find it hard studying at home and sticking to that timetable.”

Helen (Time 1 Year 1 Lombard University).

However, by Year 2 students at Lombard University had become familiar with the demands of distance learning and developed strategies for learning effectively:

“Now, I can take myself off now and do the reading – to do the work still takes me quite a while to do it, but I am getting very good results.”

May (Time 1 Year 2 Lombard University).

By the end of Year 3 and with successful completion of the programme, Lombard students were able to reflect on both the positive and negative elements. Negative elements include lingering feelings of isolation:

“...it has been a wonderful programme and I have had wonderful tutors and met wonderful people. I do feel that at times we are expected to do more on our own than what we should do ... when I started the programme and I’m the only one that is down here, and there is people to help us but I was not always able to do that, and they got together quite a lot, and I feel very, very isolated.”

Margaret (Time 2 Year 3 Lombard University).

Although distance learning brings with it challenges of its own they are in some respects not dissimilar to those of students taught on campus. For example, students at Castleton also have to

learn to maintain motivation and focus on their studies and work independently as noted above, and as Cath explains:

“If I am just left at home and told you know you don’t have to come in for the next three or four weeks [...] I haven’t got the motivation. I need and I feel like they [lecturers] are not interested in us becoming nurses.”  
Cath (Time 1 Year 2 Castleton University)

In addition, attending a physical setting can bring problems of its own:

“Every single penny that I get from the bursary I give straight to the childminder, I don’t see it at all.”  
Annya (Time 2 Year 1 Castleton University).

In summary, the qualitative findings on developing academic skills and understanding indicate that in early parts of their studies students can struggle to connect some academic “theoretical” learning to nursing practice. As time progresses students develop academic skills which support effective learning. They learn the importance of reading and seek support from a range of people to develop academic competence and confidence. The primary mode of academic teaching may vary but students at both universities report that they must learn to focus on their studies and both find the academic journey a challenging one. Both strive to become competent and confident academic learners.

### ***Developing academic skills: quantitative findings***

The survey (Section B) sought the impact of continuing to work as an HCA during programmes and asked if this helped students in their academic studies (Table 6.6).

**Table 6.6 The impact of working as an HCA during the pre-registration programme (4)**

“My work experience as an HCA helps me in my academic studies.”

	T1 Y1 n (%)	T2 Y1 n (%)	T1 Y2 n (%)	T2 Y2 n (%)	T1 Y3 n (%)	T2 Y3 n (%)
Always	14 (48.3)	12 (36.1)	10 (25.0)	8 (28.6)	15 (25.4)	19 (25.4)
Sometimes	14 (48.3)	9 (33.3)	26 (65.0)	18 (64.3)	36 (61.0)	26 (50.0)
Never	1 (2.2)	6 (22.2)	4 (10)	2 (7.1)	8 (13.6)	7 (13.5)
Missing	15 (34.1)	11 (28.9)	6 (13.0)	9 (24.3)	11 (15.7)	10 (16.1)

Valid percentages are recorded but results should be treated with caution due to missing data. However, across time and year groups students recorded high scores of sometimes/always finding working as an HCA during the programme helped with academic studies (96.6; 69.4; 90.0; 92.9; 86.4; 75.4). Highest rates were recorded at Time 1 Year 1, and lowest at Time 2 Year 1, and the second lowest score was at the end of the programme (Time 2 Year 3).

To understand more about influences on academic confidence the GLM was fitted across year groups to find out if there was statistically significant relationship between academic confidence and the CLE. The CLE was split into high, medium and low support (taken from survey question 16) for the independent variable (Table 6.7).

**Table 6.7 Relationship between the clinical learning environment and academic confidence across cohorts**

Academic confidence						
	T1 Year 1	T2 Year 1	T1 Year 2	T2 Year 2	T1 Year 3	T2 Year 3
The clinical learning environment						
"F" ratio	3.266	.008	7.006	3.283	.876	1.066
df	2,40.	2,34	2,41	2,34	2,66	2,59
Sig.	.049	.992	.002	.050	.421	.351

At the beginning of programmes, Time 1 Year 1, and throughout Year 2, the clinical learning environment was demonstrated to be significant with regard to academic confidence. Parameter estimates were examined to find the direction of the relationship, though none was evident (Appendix 6.2). Medium support was significant in Year 1 and low support in Year 2.

To find out if other variables had a statistically significant effect on academic confidence, further tests were conducted. To test if years worked as an HCA, former workplace, continuing to work as an HCA and feelings (independent variables) had an impact on academic confidence (dependent variable), GLM tests were performed individually for each independent variable and each independent variable was split. These tests mirrored the splitting of the independent variables when the clinical and professional confidence measures were tested using the GLM

(see Section 6.2 above). Test results (Appendix 6.3) showed that the relationship between academic confidence and continuing to work as an HCA was significant at the beginning of programmes (Time 1 Year 1: F ratio 2.840,  $p=.050$ ,  $n^2=.328$ ), and years worked as an HCA at the beginning of Year 3 (Time 1 Year 3: F ratio =4.430,  $p=.003$ ,  $n^2=.20$ ). The strength of these effects measured by  $n^2$  was strong. Stress was found to be a significant factor impacting on academic confidence at the end of the programmes of study, with higher levels of stress associated with lower levels of confidence (Time 2 Year 3: F ratio =4.312,  $p=.020$ ,  $n^2=.167$ ) and again the effect was strong.

The cohort samples were too small to support extended analysis GLM which included and adjusted for age, gender and academic qualifications. This became self-evident when Levene's test could not be calculated. This also proved to be the case for clinical and professional confidence.

In summary, quantitative findings show high percentage scores across time and year groups of students who found that working during the programme sometimes/always helped with their academic studies. Quantitative findings also record that CLE support and academic confidence were significantly related at the beginning of Year 1 and at both time points in Year 2 (Table 6.7). Continuing to work as an HCA was also significant and strong at Time 1 Year 1. Years worked as an HCA and stress were found to impact significantly at Time 1 Year 3 and stress at the end of the programmes, based on  $n^2$  which suggested a strong effect.

### **6.3.3 Theme 4 summary: The academic role**

In summary, the interviews revealed that students harbour fears and misgivings about the academic role, but despite these feelings academic confidence develops over time. The quantitative data provided specificity, showing that academic confidence is highest at the end of the programmes and lowest at the beginning, but at the end of Year 2 confidence is also low.

The interviews also indicated that in early parts of their studies students can struggle to connect academic "theoretical" learning to nursing practice. As time progresses students develop academic skills such as reading which facilitates effective learning, and alongside they seek support from a range of people to develop academic competence and confidence. The primary



mode of academic teaching may vary but students at both universities report that they must learn to develop focus on their studies, no matter the mode of delivery. The interviews indicated that linking theory and practice could be problematic, particularly in early parts of programmes. The survey data indicates that the relationship between the CLE and academic confidence is statistically significant at the beginning of Year 1 and at both time points in Year 2 (Appendix 6.2).

Continuing to work as an HCA during the programme also had an impact. High scores across cohorts were recorded of students who found that that working during the programme helped sometimes/always with their academic studies, and GLM tests found that continuing to work had significant impact at Time 1 Year 1. Years worked as an HCA were found to be statistically significant at Time 1 Year 3. In addition, stress was found to be significant at the end of the programmes (Time 2 Year 3) with respect to academic confidence. However, by the end of studies students' academic confidence had increased and students had learned to successfully perform academically.

## **6.4 Theme 5: Becoming a professional**

Moving on from the HCA to student nurse role in readiness for the RN role requires not just clinical and academic development but also includes personal change and new ways of seeing the world.

### **6.4.1 Becoming a professional: qualitative findings**

Lizzie, interviewed at the end of Year 1, indicated that she had developed a whole new perspective on nursing which spilt over to her entire life:

"I feel that a veil has been lifted. And sometimes I sit there and think well you know when I started the course I remember thinking that the different skills that I would get not the different perspective ... the commitment to ... for life that is the big thing. That's how I feel, it's a commitment for life. The whole of everything in your life changes."  
Lizzie (Time 2 Year 1 Lombard University)

John, looking back over his first year, explains that changing status and work role can alone be sufficient to engender change:

"I think with the nursing sort of status then you just feel more sort of into your role and I think with that sort of, with having that title I just felt more confident and more self-assured in myself. So I think that was to do with it."  
John (Time1 Year 2 Castleton University)

Margaret indicates that the first year can be a time of great role adjustment:

"It took that long. I felt like a proper student after I had done that [first placement at end of Year 1]. Because I think that my first placement I did a lot of different things."  
Margaret (Time 2 Year 3 Lombard University)

This quotation also suggests that part-time Lombard University students may wait some considerable time for a long placement outside of their home base, and this may constrain moving to the student role. However, Annil, on a full-time course and having experienced many placements, still feels that by the end of year two he is not fully a student nurse. Unlike Margaret, he has not worked as an HCA during the programme so this is unlikely to be a contributing factor.

"Um I think 80%. I still have this thought of being an HCA [...] I am still adjusting. Also at the end of this year like what they [lecturers] have been telling us as the year pass as this year goes by we are in moulding year – how to be a professional."  
Annil (Time 2 Year 2 Castleton University)

Students with prior HCA experience explain that by Year 3 they feel they are a student and no longer think of themselves as HCAs:

Interviewer "Do you ever still feel like a HCA?"  
Simone "No, not at the moment. Though sometimes we do those duties in different wards but I don't feel like an HCA any more."  
Simone (Time 1 Year 3 Castleton University)

By the end of programmes students are ready to move to the new role, albeit with mixed emotions:

Interviewer "And are you excited about being a registered nurse?"  
Moyra "I can't wait. I can't wait. Nervous very nervous"  
Interviewer "What are you nervous about?"  
Moyra "Because there is so much more to learn isn't there? You will never know everything you are never going to know everything but I almost feel that the nursing course only gives you the basics. It could be a ten year course and you would still only have the basics until you get out there and you are doing it yourself and you don't learn until you get out there and do it yourself"  
Moyra (Time 1 Year 3 Castleton University)

Students become aware of personal transition which takes place as the programme progresses. They talk of developing into a better-rounded person, of growing up despite their chronological age and of stepping up to the challenges of studentship:

"I have grown up if that is possible ... I was 50 when I started this and just turned 54 when I qualify and I do know that I have changed and I am sure that my husband would agree erm I don't know how but I just know that I have erm I have got a lot I have got a lot more sympathetic and I understand things now."  
Amanda (Time 2 Year 2 Lombard University).

By the time students have completed the programme they express both personal and professional change:

“I have changed in my personal self; I am more able to manage myself better the management skills that I gained just from training as a nurse I feel like I have grown up ... the way that I look at things now I feel that I am almost worthy of looking after people and I feel I can give them the care and I have the skills now because now I can manage myself and my time and I can prioritise things a lot better.... and I feel like a professional ... I have come from HCA where I did not really I did not feel, I felt proud to put on my uniform when I was an HCA, but now I feel very much more putting on my uniform this time and I do feel like a professional now.”

Sharon (Time 2 Year 3 Castleton University).

Sharon feels she has gained the knowledge and skills required of a professional and in so doing is a changed person. She articulates the transition from HCA to student nurse and is now ready to start a new transition to staff nurse.

In summary, the qualitative findings show that becoming a professional nurse involves personal change as well as clinical and academic change. Year 1 was found to be a time of great change and change continued until the end of programmes. By the end of their studies students felt they have become a professional, a more mature person as well as a practitioner.

#### 6.4.2 Becoming a professional: quantitative findings

The survey asked students to consider how their former job as an HCA affected their adjustment to clinical practice (Table 6.8)

**Table 6.8 The effect of former HCA job on adjusting to the student role**

“I find it difficult to adjust to being a student nurse in clinical practice.”

COHORT	Never n (%)	Sometimes n (%)	Always n (%)
T1 Y1	6 (13.6)	33 (75.0)	5 (11.4)
T2 Y1	18 (47.4)	19 (50.0)	1 (2.6)
T1 Y2	13 (28.3)	30 (65.2)	3 (6.5)
T2 Y2	10 (27.0)	26 (70.3)	1 (1.3)
T1 Y3	17 (24.3)	48 (68.6)	5 (7.1)
T2 Y3	22 (35.5)	36 (58.1)	4 (6.5)

Findings indicate that 11.4% of students at the beginning of the programmes record that they always found adjustment to being a student difficult and 75% sometimes did. These are the

highest figures across all year groups. Time1 Year 1 is also when the least number of students across all year groups record never finding it difficult to adjust (13.6%). However, by the end of Year 1 the figure for never finding adjustment difficult leaps to 47.4%, as students get to grips with their new role. Thereafter the figure falls and by the beginning of Year 3 7.1% of students always found it difficult to adjust and 68.6% were sometimes still finding it difficult to adjust to the student role. However, by the end of Year 3, 35.5% of students record they never have problems.

In Chapter 5, Themes 1 and 2 presented measures of professional and clinical confidence (Figures 5.3 and 5.4) across cohorts and Figure 6.3 (above) presents academic confidence across cohorts. They show that clinical, professional and academic confidence measures increased by the end of programmes. GLM tests (Table 6.9) provides a summary of all three measures, their means and standard deviations across time and year groups. Pair-wise comparisons between time points/cohort groups and the last time point (Time 2 Year 3) are shown. All other pair-wise comparisons between the six groups (e.g. Time 1 Year 1 vs Time 2 Year 2) were not statistically significant.

In Table 6.9 pair-wise comparisons findings indicate that when compared to other time and years the final group (Time 2 Year 3) are significantly different to the others on all three measures of confidence. The only exception is clinical confidence at Time 2 Year 1 which just falls short of statistical significance. The table indicates that at the confidence measures have significantly changed by the end of the programmes.

A summary of all three dependent variables – clinical, professional and academic confidence – is presented below in Table 6.10 with the GLM tests which demonstrated significance on the range of independent variables discussed above: years worked as an HCA; former workplace; hours continuing to work as an HCA; feelings; the CLE. While statistical significance demonstrates the probability of the impact of the variables on confidence measures, it does not show the degree to which two variables are associated. Therefore,  $n^2$  (partial Eta squared) statistics are included in the table to provide an indication of the size of the effect of independent variables on confidence measures.

**Table 6.9 Clinical, professional and academic confidence: change across cohorts**

	<b>T1 YEAR 1</b>	<b>T2 YEAR 1</b>	<b>T1 YEAR 2</b>	<b>T2 YEAR 2</b>	<b>T1 YEAR 3</b>	<b>T2 YEAR 3</b>
<b>CLINICAL CONFIDENCE</b> Q14 Difficult situations nurses experience (possible score range 8–24)						
n (%)	44 (100)	38 (100)	45 (97.8)	37 (100)	69 (98.6)	62 (100)
Mean (Std.Dev.)	18.52 (3.01)	19.05 (2.81)	18.20 (3.18)	18.76 (3.06)	19.03 (2.79)	20.21 (2.47)
Pairwise comparisons: T2 Y3 Mean difference (95% CIs) Lower Bound Upper Bound	*1.68  .58 2.80	1.15  .00 2.32	*2.01  .91 3.11	*1.45  .28 2.62	*1.18  .19 2.17	
<b>PROFESSIONAL CONFIDENCE</b> Q17 Role of the RN (possible score range 12–36)						
n (%)	44 (100)	38 (100)	46 (100)	37 (100)	70 (100)	62 (100)
Mean (Std.Dev.)	30.70 (3.78)	32.65 (2.52)	31.15 (4.08)	32.57 (3.18)	32.34 (3.30)	34.58 (2.15)
Pairwise comparisons: T2 Y3 Mean difference (95% CIs) Lower Bound Upper Bound	*3.876  2.63 5.12	*1.923  .62 3.23	*3.428  2.20 4.66	*2.013  .70 3.33	*2.238  1.14 3.34	
<b>ACADEMIC CONFIDENCE</b> Q22 Academic confidence (possible score range 22–66)						
n (%)	44 (100)	38 (100)	44 (95.7)	37 (100)	69 (98.6)	62 (100)
Mean (Std.Dev.)	52.26 (7.26)	55.31 (7.50)	52.86 (7.42)	52.86 (7.35)	54.74 (7.51)	59.79 (5.55)
Pairwise comparisons: T2 Y3 Mean difference (95% CIs) Lower Bound Upper Bound	*7.535  4.78 10.30	*4.475  1.61 7.34	*6.927  4.19 9.67	*6.925  4.03 9.81	*5.051  2.62 7.48	

\*The mean difference is significant at the .05 level

**Table 6.10 Summary of significant relationships between years worked as an HCA; former workplace; hours continuing to work as an HCA; feelings; and the clinical learning environment AND clinical, professional and academic confidence measures**

TIME AND YEAR GROUP	INFLUENCING FACTOR(S) AND CONFIDENCE MEASURE	GLM sig	Partial Eta squared ( $\eta^2$ )
	<i>CLINICAL CONFIDENCE</i>		
T1 Y1	Stress AND negative feelings	.044 .018	.200 .426
T2 Y1	–		
T1 Y2	–		
T2 Y2	–		
T1 Y3	--		
T2 Y3	--		
T1 Y1	--		
	<i>PROFESSIONAL CONFIDENCE</i>		
T1 Y1	–		
T2 Y1	positive feelings	.040	.357
T1 Y2	–		
T2 Y2	positive feelings	.004	.551
T1 Y3	–	.007	.232
T2 Y3	–		
	<i>ACADEMIC CONFIDENCE</i>		
T1 Y1	Continuing to work as an HCA AND CLE	.050 .049	.328 .140
T2 Y1	–		
T1 Y2	CLE	.002	.255
T2 Y2	CLE	.050	.162
T1 Y3	Years worked as an HCA	.003	.200
T2 Y3	Stress	.020	.167

Each finding can be interpreted as having a large effect on the dependent variables based on  $\eta^2$ .

The confidence measures stress and negative feelings play their part at the beginning and end of programmes, while positive feelings have large effects at the end of Year 1 and again at the end of Year 2. Hours of paid work as an HCA impacts on academic confidence at the start of programmes, but prior work experience (years worked) and former workplace have little impact on any confidence measure. No single variable has a continuous impact across time and year groups, though the CLE has a large impact in Years 1 and 2 with respect to academic confidence.

In summary, the quantitative data shows that Year 1 is a time of adjustment to the student role, but by the end of programmes adjustments, while still occurring, are not as frequent. All three confidence measures indicate that there is a significant increase in confidence by Time 2 Year 3 compared with other cohort time points in dealing with difficult situations, upholding the role of the RN and academic confidence. Factors which might impact on these measures – years worked as an HCA, former workplace, hours continuing to work as an HCA, positive and negative feelings – do not show trends over time and year groups. Only the CLE has a significant effect over time on academic confidence, specifically at the beginning of Year 1 and throughout Year 2.

#### **6.4.3 Theme 5 summary: Becoming a professional**

Students explained during interviews that becoming a nurse involves developing personal maturity as well as clinical and academic change and development. By the end of their studies students explained that they felt they had become a professional nurse, a more mature person as well as practitioner. The interviews also indicated that Year 1 is a time of considerable adjustment to the student role, and the quantitative data in Table 6.9 confirms this finding. It also demonstrates that adjustment continues up to the end of programmes. The confidence measures, clinical professional and academic, were shown to be significantly better at Time 2 Year 3 when compared with other cohort time points. Factors which might influence the confidence measures: years worked as an HCA, former workplace, hours continuing to work as an HCA; positive and negative feelings, did not exhibit trends over time and year groups, although stress and negative feelings play their part at the beginning and end of programmes, while positive feelings have large effects in Year 2, and again at the beginning of Year 3. However, the CLE was demonstrated to have a large impact in Years 1 and 2 with respect to academic confidence.

### **6.5 Summary of the main findings**

Five themes were found in the data which explain the journey from HCA to RN and develop understanding of it – the overarching aim of the study. The five themes are: Wanting to be a nurse; The practice milieu; Embracing the clinical role; The academic role; Becoming a professional. The themes are grouped into two sections; the first two themes are concerned with the context of being a student nurse and changing perceptions of work roles and the second three themes concerned with learning to be a student nurse and preparing for registration as a nurse.

These two sections reflect change over time as students move from their former role, and enter the uncertain and uncomfortable student role before becoming accepted as an RN.

All themes describe the experiences of former HCAs and the impact of studentship on them (Objectives 1 and 2). They also point to the people, structures and processes which can facilitate and constrain transitions (Objective 3) and all themes contribute to the study aim. A model of transitions (Objective 4) is presented below in Chapter 7, built on the findings. Together all themes contribute to the aim of the study. The relationship of themes to the study objectives follow.

The first theme describes the motivations experienced by former HCAs for wanting to become a student nurse. Findings indicated that students forego the financial and emotional security of their old role in exchange for the uncertainties of the new. This theme describes the impact on students of their changing perceptions of their old role and clinical practice settings. They began to see the HCA role as task- and time-orientated, where knowledge to underpin practice was limited. They also revised their view of the RN. Students began to recognise the scope and accountability inherent in the RN role and this was a source of great anxiety. The survey found that 63% of students had worked for more than five years as an HCA, 56% gained their experience in hospital settings, and their professional confidence levels were high across studentship. However, mixed emotions were experienced as former HCAs struggled to come to terms with the student role. This also impacted on family, friends and peers who provided support to facilitate students' transitions.

Theme 2 found that throughout their studies students had high confidence in dealing with difficult situations nurses experience. However, contrary to expectations, students also found prior experience did not inevitably transfer readily or easily to their student placements. They expressed shock that it did not readily facilitate their transition to student nurse as they had assumed it would. Students also began to see the importance of RN mentors to support and guide them through the transition to becoming a student nurse then RN. They recognised that practitioners can not only facilitate progression but also constrain it through poor supervision/mentorship and unsupportive practice environments. On occasion they were involuntarily allocated the HCA role when placements were short-staffed and felt they were more



likely than other students to be asked to do this. However, the survey recorded high levels of clinical and professional confidence across studentship and interviews indicated students felt it important to project confidence. By the end of programmes professional and clinical confidence measures were significantly different from those recorded at other times.

Theme 3 demonstrated how former HCAs embraced the clinical role, endeavouring to move from a task/time-orientated support role and develop their knowledge base. Students had to accept constant appraisal of their performances and leave behind the non-assertive HCA role to become a proactive learner. However, they found this could be at the expense of patients' needs, which were often all too apparent to them. They learned to question and observe practice and practitioners, and developed a range of strategies such as reading to support their learning. They also had to learn how to portray the demeanour and manner expected of RNs while divesting themselves of the HCA role.

The impact of prior experience could be a constraint and students felt expectations of them were higher than of those with no prior experience. This resulted in the dilemma of whether or not to admit to prior experience when starting a new placement. Students also feared that they had been taught incorrectly when an HCA and had acquired bad practices. However, they also reported that prior HCA experience promoted their confidence in approaching patients. When they felt tired and overwhelmed students could voluntarily slide back into their former HCA role. They stated they did not experience boundary confusion when working as an HCA during programmes and increasingly used it as additional clinical learning time.

Theme 4, the academic role, found that students' academic confidence was low, particularly at the outset of their studies, and they feared academic failure. However, descriptive statistics showed confidence increasing over the studentship period. There was also a statistically significant relationship between the clinical learning environment and academic confidence at the start of programmes and throughout Year 2. Also, working as an HCA during the programme was statistically significant with respect to academic confidence at the start of programmes (Time 1 Year 1). In addition, stress related to academic confidence was statistically significant at the end of programmes (Time 2 Year 3) when compared with other cohorts and time points. As with

clinical learning, academic learning was promoted when students learned a range of strategies and identified staff who could facilitate passing assessments.

Theme 5, becoming a professional, indicated that by the end of programmes students felt they had become a professional person. They had experienced considerable adjustment to the role of student nurse. Their clinical, professional and academic confidence grew over their programmes of study and was statistically significant at the end of Year 3 compared with other cohorts and time points.

Stress and negative feelings were statistically significant at the start of Year 1 and impacted on students' clinical confidence. Positive feelings were statistically significant at the end of Year 1 and again at the end of Year 2 with respect to professional confidence. Other factors which might impact on clinical and professional confidence were tested: years worked as an HCA; former workplace; continuing to work as an HCA during programmes. No trends were evident and no relationship was found. By the end of programmes the changes students experienced were not only clinical, professional and academic but were also developmental and students had often gained maturity as a person. They felt they were a changed nurse and a changed person, ready, if somewhat nervous, to become a professionally accountable RN.

The next chapter discusses these findings and their implications.

## Chapter 7 Discussion

### 7.1 Introduction

This chapter discusses the findings from this study and presents a model of transition from experienced worker to professional qualification. Section 7.2 re-presents the study aim and objectives and a summary table outlines the main findings. Next, Section 7.3 introduces the theoretical perspectives which in this present study are used to explain and understand the transition from HCA to Registered Nurse. Section 7.4 presents and discusses a model of the transition from HCA to RN, based on the empirical findings from this study. Section 7.5 summaries the discussion. Section 7.6 presents the implications of the study, Section 7.7 its limitations, Section 7.8 the contribution this study has made to knowledge and Section 7.9 concludes this thesis.

### 7.2 Study aim, objectives and outline of findings

The aim and objectives of this study were:

**Aim:** To understand the work role transition to RN of student nurses who were formerly employed as Health Care Assistants.

**Objectives:**

- 1 To explain students' experiences of the transition process.
- 2 To explore the impact of work role transitions on students.
- 3 To identify and discuss the facilitators and constraints to transition from Health Care Assistant to Registered Nurse.
- 4 To develop a model to explain the transition from Health Care Assistant to Registered Nurse.

**Table 7.1 Outline of findings**

FINDINGS I: CONTEXT AND CHANGING PERCEPTIONS	
THEME 1	WANTING TO BE A NURSE Getting started: motivations, risks, assumptions Changing perceptions – mixed emotions
THEME 2	THE PRACTICE MILIEU Transferring prior experience Support for learning

FINDINGS II: BECOMING A STUDENT NURSE	
THEME 3	<b>EMBRACING THE CLINICAL ROLE</b> Learning to be a student nurse Developing a knowledge base The impact of prior experience on embracing the student role Expectations by staff of former HCAs Bad habits Backsliding Wearing two hats
THEME 4	<b>THE ACADEMIC ROLE</b> Academic confidence Developing academic skills and understanding
THEME 5	<b>BECOMING A PROFESSIONAL</b>

The main theoretical perspectives which explain and develop understanding of the transition of HCAs from experienced worker to professionally qualified person, an RN, are presented next.

### 7.3 Theoretical perspectives on work role transitions

The discussion which follows draws on two key theories; Goffman's role theory and van Gennepe's transitions theory. The classic anthropological study of cultural celebrations presented by van Gennepe ([1909] 1960) provides a backbone for understanding of the pattern of transition students' experience. As noted in Chapter 2, he analysed ceremonies described as "rites of passage", and identified three major stages of transition: separation, transition and incorporation. These explain what happens as an individual moves from one role or status to another. Separation is characterised by removal of the individual from his or her usual social life. Transition is a liminal state where the individual no longer belongs to the previous status and has yet to complete passage to the next. It is a "no man's land" which was regarded by van Gennepe as potentially threatening and harmful. Rituals are associated with the stages and when the passage is completed the individual assumes a new status and is incorporated into a new group. Van Gennepe's work has been criticised as descriptive and functional and lacking application to a post-modern society (Watts 2013). However, as Holland (1999) found and this study has also found, the pattern of transition van Gennepe identified is useful to explain student nurses' transitions. Van Gennepe ([1909] 1960) hypothesised that this pattern exists irrespective of type of status passage. However, he was more concerned with establishing the universality and validity of the process of

transition and the pattern of change over time. He was less concerned with how and why the process occurs, often leaving them as unstated assumptions in his analyses (Kimball in van Gennep [1909] 1960, Gluckman 1962).

This study also draws on Goffman's role theory (1959) to explain and understand the how and why of what students experience within the pattern of transition. It also helps to explain the impact of studentship and what facilitates it and what doesn't. As discussed in Chapter 2, Goffman presents a theatrical or dramaturgical interpretation to describe everyday events. His major achievement lay in his ability to pursue the theatrical metaphor beyond the commonplace notion of "putting on an act". He built an analogical framework which fully exploited the theatrical metaphor (Fine & Manning 2003). He explains that individuals learn to act out a role and put on a performance which allows others to define the situation. Sources of information and sign vehicles (or carriers) become available for conveying information. Observers can glean clues from conduct and appearance which allow them to apply their previous experience with roughly similar individuals. The actor for his part can control the conduct of others, especially their responses to situations, by expressing themselves in such a way as to give an impression that will lead the observer to voluntarily act in accordance with the plan of the actor (Goffman 1959).

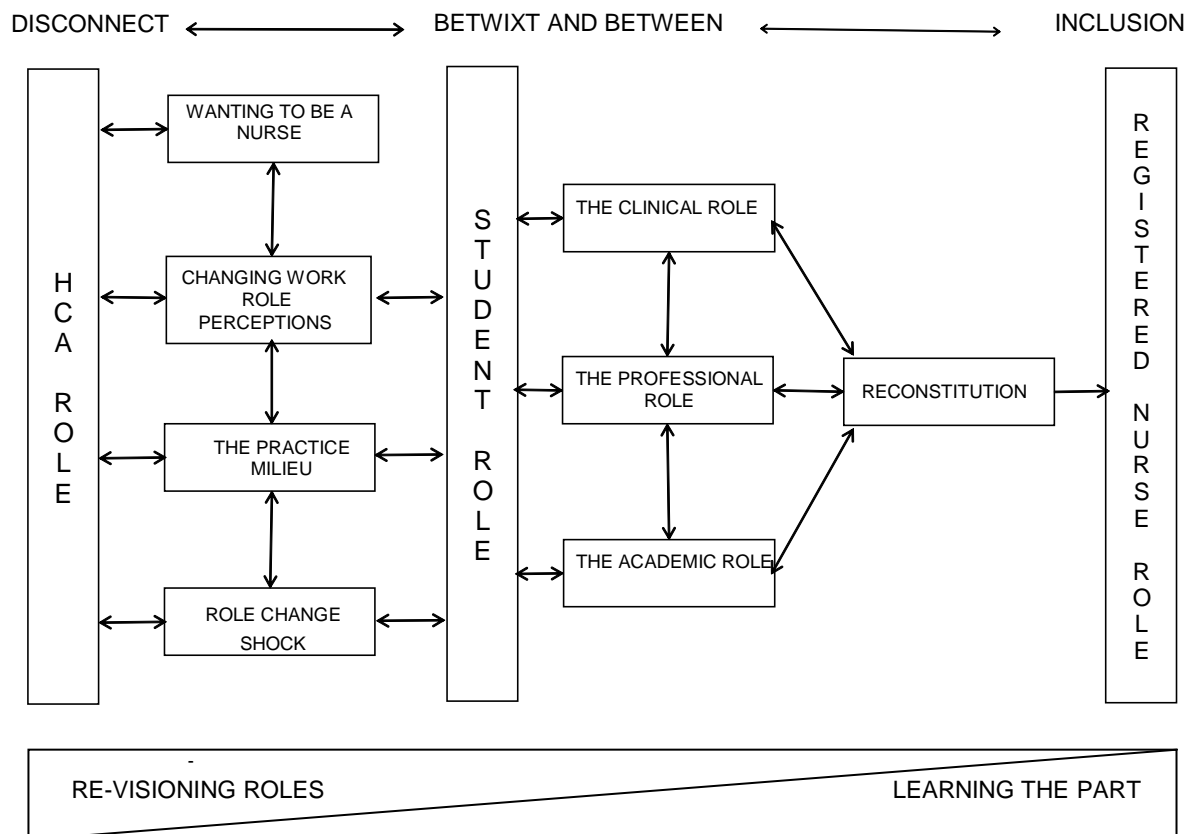
In the following discussion transitions theory provides an analytical and contextual superstructure, a framework explaining the pattern of change from HCA to RN. The strength of the transitions theory is that it highlights the pattern of change over time, and within this framework the dramaturgical approach provides in-depth insights into experiences of change. Other perspectives are also drawn on in this chapter to deepen the discussion. Most notably, Benner (1984) for insights into experiential learning and skill acquisition in nursing practice, Kramer (1974) for insights into nursing work organisation and role shock, Brennan and McSherry (2007) for their theory of the transition from HCA to RN, and Bridges (1995) and Nicholson and West (1989) for their theoretical orientations to work role transitions.

## 7.4 From experienced worker to professional qualification: HCA to RN

### work role transitions

#### 7.4.1 The HCA to RN model of work role transitions

A model of the work role transition from HCA to RN is presented next based of the findings of the present study. (Figure 7.1). The content of the model structures the discussion which follows.



**Figure 7.1 From support worker to professional qualification: the health care assistant to Registered Nurse model of work role transition**

#### *An overview of the model: shape and structure*

The three stages of transitions presented at the top of this model – disconnect, betwixt and between and inclusion – like a picture frame provide an overall shape and structure to the journey of transition. All other parts of the model are concerned with the contents within this frame, with roles, role theory and role learning, although these two major parts of the model, the superstructure and the content, are inextricably linked. The first stage of the transition frame, its superstructure, is “disconnect”. This is concerned with separating from the old HCA role, while the

betwixt and between stage signifies being a student and neither an HCA nor an RN, and the inclusion stage is finally reached when HCAs are formally included in the register of nurses.

The three stages in the present model reflect van Genneep's model of transition (separation, transition, incorporation), but in the present study the stages were not found to be discrete and are not presented in the model as linear stages, as in van Genneep's interpretation. Instead it was found that students could move back and forth between the stages throughout studentship. Nonetheless the three stages have prescribed start and end points as students enter and exit pre-registration programmes of study. Others who have studied transitions, and work role transitions in particular, have found non-linear trajectories. Both Nicholson and West's (1989) and Bridges' (2009) models of work role transitions suggest overlapping strata exist when individuals' work roles change. Nicholson's five-stage model is also explained as recursive. The last stage of one cycle is the first of the next and if change is rapid, Nicholson suggests, cycles can short-circuit one another. Bridges too acknowledges the recursive nature of transition processes and explains that individuals can be in more than one phase at any one time, and suggests that movement through transition is marked by the dominance of one phase as it gives way to the next.

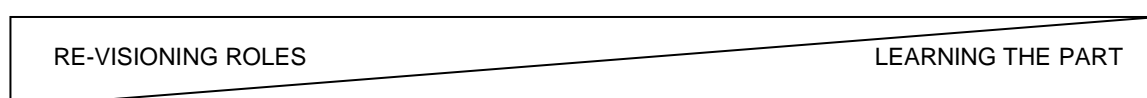
Brennan and McSherry (2007) proposed a model of transition from HCA to student nurse which they stated could be developed. The model from this present study (Figure 7.1) builds on the Brennan and McSherry model (Appendix 7.1). It adds a transitions theoretical superstructure to frame the process of change from HCA to RN. The Brennan and McSherry model suggests how students move from HCA to the student role and the present model extends the transition to the point of incorporation into the RN role. Three roles are presented within this model: 1) the HCA role, which is the starting point; 2) the student role, characterised by the betwixt and between stage; 3) the RN role and the stage of incorporation, the point at which the experienced worker, the HCA, becomes professionally qualified.

The first main section of the Brennan and McSherry model was derived from the published literature rather than their empirical findings. The present study model's first section, although grounded in the literature, also incorporates the findings from the present study. The Brennan and McSherry model presents the comfort zone as a new finding and findings from this present study confirm its presence. In the present study model the comfort zone is conceptualised as a

constituent part of the learning the clinical role and along with other constituents is discussed in relation to the clinical role. The Brennan and McSherry model suggests that former HCAs' transition experiences move through culture shock to professional and clinical issues and to the comfort zone. From the accompanying text it is unclear how culture shock is conceptualised and in what way it is seen as different from reality shock. The present study model includes shock, but it is conceptualised as role change shock and is discussed in detail below. Also, the academic segment of studentship is included in the present study model but not in the Brennan and McSherry model. The present study model presents the transition process as recursive and the Brennan and McSherry model is presented as a largely linear process. However, both models indicate that prior work role experience carries challenges into studentship.

### ***The HCA to RN model content***

The present study model incorporates two overlapping strata: “re-visioning roles” and “learning the part” (Figure 7.2). As with other model contents, they are conceptualised as occurring within the disconnect→betwixt and between→inclusion stages of transition. They explain the two key elements students experience as they move towards RN status.



**Figure 7.2 Two overlapping strata**

The two strata reflect the Findings I chapter title “Context and changing perceptions” and the Findings II title “Becoming a student”, and are underpinned by Goffman’s role theory. As the Findings chapters show, former HCAs throughout studentship encounter a number of clinical placements as well as movement in and out of university. The changes they experience are rapid and short-circuiting of stages can occur as individuals’ understanding of roles and how to enact them is developed over programmes. These are overlapping processes and are not time bound, although, as the model suggests, “re-visioning roles” is most dominant early in programmes and “learning the part” becomes increasingly dominant as studentship progresses.



#### **7.4.2 Re-visioning roles**

The re-visioning process marks out disconnecting from the old role and is the first element in the transition process. This study found that “disconnect” began with wanting to be a nurse, followed by changing perceptions of work roles, the ensuing shock and coming to understand the value and nature of support roles in the transition to RN. These four elements were found in Theme 1 (Wanting to be a nurse) and Theme 2 (The practice milieu). They are presented in four boxes located towards the “disconnect” stage of the model (Figure 7.1), indicating their dominance early in the transition process. “Disconnect”, while mirroring van Gennepe’s “separation” stage, also indicates that students voluntarily leave an established work group and the values and behaviours of that group. It also signifies that this is not an inevitable or expected role change, as with van Gennepe’s anthropological interpretations based on tribal societies and changes such as birth, adolescence, marriage and death.

##### ***Wanting to be a nurse***

The first element in the model, wanting to be a nurse, propelled former HCAs into studentship and marked the first departure from the old role and projection into the betwixt and between stage which characterises studentship. Disconnecting from the old role was motivated through a desire to be a nurse even though this risked financial, emotional and work security associated with the old role. It was also found that students risked the ignominy of failure should they not “pass” the programme, with the prospect of returning to their former HCA role. Motivation can be drawn on throughout the transition period as the model suggests, and interviews found that students drew on the support of family, friends and peers throughout studentship to maintain motivation. Knight *et al.* (2012) and McKendry *et al.* (2014) also noted their importance and found that the support they gave is the greatest of reasons student nurses continue their studies. They also found that university academics are less influential, as was indicated in this study. The quantitative data indicated that discussions of HCA experience were least likely to be held with tutors and lecturers.

According to Goffman (1959), in highly stratified societies there is a tendency of idealisation of the higher strata and aspiration of those in lower strata to move to higher ones. This is borne out in the findings from the survey and interviews which indicated that wanting to be a nurse was a long-held desire, and that wanting to develop careers was also important. Further, the survey also found that motivations included increased financial recompense. However, this was not

mentioned during interviews. This may be explained by Goffman's (1959) suggestion that individuals conceal or underplay activities and motives which they believe are incompatible with the idealised version of the role. Students, it can be argued, were acting out "altruism", as befitting the idealised role of the RN, while encouraging the researcher, their audience, to believe they were related in a more ideal way than perhaps was the case.

### ***Changing work role perceptions***

Findings indicated the HCA role was re-visioned as one of task orientation, limited knowledge, responsibility and accountability where limitations largely went unrecognised. In contrast, the RN role was reconceptualised as one of wider breadth and scope, and of greater accountability, responsibility and knowledge than was formerly recognised. Formerly, as an HCA, students believed there was little difference between the HCA and RN roles. Many believed all they needed do was learn to do the medicines and write reports. This may be explained by Kramer's interpretations of the work environment. Former HCAs, it can be argued, brought to studentship the behaviours and values associated with "part-task systems" or "bureaucratic system of work" characterised by car assembly lines. Herein skills are "particularistic" rather than "universalistic" (Kramer 1974, p. 13). The role of the RN can be conceptualised as associated with "universalistic" skills and with "whole-task systems". This work system is organised on the whole task principle and requires that "the worker possesses all the immediately and potentially necessary knowledge and skills to do the total job" (Kramer 1974, p. 13). Former HCAs were required to re-orientate their approach to nursing based on the whole task rather than individual parts. Also, because the RN oversees the entire nursing task, they are internally coordinated and external controls are not needed (Kramer 1974). Instead, behaviours and norms are laid out by the professional body, the NMC, as codes of ethics and performance and maintained by peers. It was to these standards former HCAs found they must adhere.

### ***The practice milieu***

The re-visioning phase found students re-visioning practice areas and staff roles. Students described their former HCA role as backstage where they felt invisible but as a student nurse they felt they became visible. They re-visioned their view of the RN role, describing it as "front line". Students felt this was where they were now operating and where surveillance by practitioners was constant. Goffman (1959) suggests there are back and front stage regions where performances

take place. These regions can be read quite literally as being physical locations. However, they can also be understood as less concerned with architecture and more with a metaphorical description of familiar experience (Fine & Manning 2003). Goffman (1959, p. 109) explains that a region can be defined as any place that is bounded to some degree by barriers of perception and is permeable, taking on different meanings according to circumstances. Further, he suggests that when speaking of front and back regions it is with reference to particular performances and the function that place happens to serve at that time for the given performance. In this study the physical front stage location was similar to if not the same as the backstage region, but each was bounded by barriers of perception and each required different performances. The workplace was one for learning and re-orientating, not just working, and required a front stage performance.

This study found that to learn how to act out the student role, support from staff in clinical practice was of key importance. The interview data found that for students the most important member of the team, the one most able to facilitate their learning, was their mentor. According to Goffman (1959, p. 102), soothing and sanctioning are the processes employed by performance directors whose special duty is to ensure the important functions of the team are fulfilled. This study found that mentors as performance directors employed both, but expectations of former HCAs were high.

Soothing acts included encouraging students, displaying positive attitudes and giving feedback in a positive manner. In turn, students reported that this facilitated confidence in their role and encouraged them to act in appropriate ways. However, the quantitative data found that desirable support was lacking over in over a third of the time, and only just over half of students (56%) felt their experiences of supervision were always based on equality and promoted learning. In a systematic review of the literature, Jokelainen *et al.* (2011) reported that positive staff attitudes were of key importance to students and facilitated their development, a finding further supported by this study. However, sanctioning is also part of the role of mentors and may account for students' perceptions that support was sometimes not evident.

Sanctioning was found to be a mentor act used to bring students whose performances were deemed unsuitable in some way back into line. It involved giving feedback which highlighted deficient cues displayed during performances. Goffman suggests that performances can be

readily manipulated to gain favour from audiences, and this study found students anxious to receive feedback to adjust their performance. The ultimate sanction, that of deeming the student's performance a failure, confirmed mentors' star centre stage role status. Clinical assessments were important rites of passage and mentors held the power to decide if students' performances were sufficiently convincing to allow progression to the ultimate stage of transition – inclusion. The “inclusion” stage of the model indicates acceptance of an individual by the professional body of nurses, a person worthy of the ensuing work role and all it entails.

Findings also indicated that the wider clinical team, consisting of nurses, doctors and allied health professionals, could also facilitate or constrain students' transitions. Goffman (1959, p. 85) suggests the team goal is to cooperate in staging a single performance. In this study the teams' goal was the care of groups of patients and clients, and the survey indicated that high levels of support were available across studentship. Moreover, the survey found that consistent support was available across time and year groups with no statistical difference found regarding the clinical learning environment (CLE) and the clinical or professional confidence of students.

However, structures and processes operated by teams in health care settings can impact on students' transitions and can be constraining, as both the quantitative and qualitative data in this study found. Interviews found that staff encouraged students to revert back to the HCA role when it suited them – when the practice area was busy and staffing problems arose. Almost three-quarters of students reported that they were used as an HCA during studentship and they perceived this more likely than for students without prior experience. It may be a particular type of “ceremonial profanity” (Goffman 1956, p. 494) on the part of the student to doggedly insist on supernumerary status. Early in programmes students were learning to appreciate what are considered to be unsuitable acts and performances. Goffman suggests actors must learn how to close off avenues of perception which portray them in a poor light. Students were striving for mentor approval and refusing the HCA role was, according to findings, not an option. However, students did express discontent when forced into the HCA role involuntarily, but interviews also indicated that when in the HCA role they acted like a student. They continued to question practice, looking to answer questions of “what” and “why” in clinical practice not just “how” to perform.

The quantitative data shows the difficulties relating to the CLE were particularly felt early in programmes. A statistically significant difference was found in years one and two with respect to the CLE and academic confidence. The GLM parameter estimates showed no trends over time (Appendix 6.2) and the significant results may be explained as an artefact of the data resulting from multiple testing. However, interview findings suggest that students struggle to link theory taught in the classroom to practice in clinical settings, particularly early in programmes, and this is widely reported (see: Baxter 2007, Corlett 2000, Maben *et al.* 2006, Lauder 2008, Rafferty *et al.* 1996).

The survey also found that only half (50%) of managers displayed a positive attitude and promoted learning. However, as Goffman (1959, p. 54) warns, it would be incorrect to be too cynical. If the principal ideal aims of the organisation are to be achieved it is sometimes necessary to bypass other ideals of the organisation for a short time, while maintaining the impression that these other ideals are still in force. In this study pressing students into the HCA worker role did not mean that the ideal of supernumerary status was wholly rejected. A sacrifice was made of the most visible ideal, that of the student role, in favour of the most legitimately important. The care and comfort of patients was seen as the most legitimately important ideal over and above teaching students. Moreover, findings indicated that as experienced workers students readily recognised patient needs and may on occasion have felt these could legitimately supersede their own.

Findings also indicated that students assumed and expected that skills learned as an HCA would easily and readily transfer to their student clinical placements. As already noted, skills developed as an HCA can be seen as “particularistic” rather than “universalistic” (Kramer 1974, p. 13). When repeated frequently they gave HCAs the opportunity to develop tremendous skill and speed in the performance of the task. However, as suggested above, the HCA work role is part-task orientated. In this segmented work only a few skills are needed and as in factory assembly lines these are usually learned on the job and in a relatively short period of time. However, students endeavoured to learn enough common pieces of performance to more or less manage in their next placement. They were striving to acquire “universalistic skills” (Kramer 1974, p. 13) which can be used in a variety of situations. The survey showed that confidence levels increased over time, as did the number of placements, actors and performances encountered. Enough parts of

performances were acquired to pass the placement and take forward to the next placement and develop a whole-task orientation. HCAs today are increasing in number and increasingly undertake “part-task” skills formerly the domain of RNs. This may have led students in the present study to assume and expect that existing skills plus a few more (such as learning to do the medicines) would equip them for registration, rather than a changed orientation to nursing work. Moreover, as the present study found, when assumptions and expectations are unmet they can be the source of anxiety and shock (Kramer 1974).

### ***Role change shock***

Revised perceptions of the HCA and RN roles and the clinical milieu, including its staff, particularly early in programmes, resulted in students experiencing “role change shock”. Students assumed their prior experience had prepared them for the role of student nurse and of RN, and expected it would ease their transitions, only to find it did not. The term “reality shock” was coined by Kramer (1974), whose research drew on studies of newly qualified nurses to describe the shock of unpreparedness. Kramer suggested reality shock resulted when school values, “professional values” (Kramer 1974, p. 11), were different from those neophyte nurses experienced in bureaucratic systems of work. This study suggests the role change shock experienced by former HCAs is not related to school values, since HCAs have uneven, non-prescribed and often limited educational/academic input to underpin their work role. Instead findings suggest the values and behaviours associated with part-task systems acquired in the HCA role result in shock when found to be incongruent with the student role. Role change shock describes the shock experienced when moving from an established role within a team with a part-task orientation to a role requiring a whole-task orientation. This differs from “reality shock” because newly qualified nurses, when students, rotated through clinical placements as a temporary and peripheral team member. They had not experienced being a permanent team member, as had former HCAs, and did not have to change roles and orientations within the nursing team. Moreover, they had not been employed in a role with “bureaucratic” values (Kramer 1974, p. 33) within the practice setting. However, just as Kramer found, this study has also found that when “bureaucratic” values are at odds with “professional” values, conflict and shock result.

The role change shock finding contrasts with Gray and Smith’s (1999) argument that students with prior nursing experience are protected by their prior knowledge and this reduces reality

shock. However, Brennan and McSherry (2007, p. 210) also found that HCAs turned student nurses experienced shock – “significant culture shock”, explaining this was as a result of believing that previously developed skills would carry them through the initial stages of their training. Their study also found no evidence that “reality shock” was perceived as a frightening issue. This present study suggests that fear is experienced, this being part of role change shock as students became aware of the meaning of responsibility and accountability related to the RN role. This present study also found in the quantitative data that positive feelings were low and negative feelings were high, particularly at the beginning of programmes. These feelings may have been compounded by assumptions that prior experience would ease their pathway and that the HCA role differed little from that of the RN. The premature identification with the behaviour and attitudes of the aspired-to group, or anticipatory socialisation (Merton *et al.* 1957) can be a source of dissonance (Maben *et al.* 2006, Brown *et al.* 2013). This study found unmet anticipations, that is, students’ assumptions and expectations, resulted in role change shock.

Re-visioning involved students becoming objects to themselves by seeing themselves from the outside (Blumer 1969). This may only have been possible by placing themselves in the position of others – that of student nurses – then being able to see themselves as others see them (Blumer 1969). Students’ revised views of roles indicated movement away from the old role, a “disconnect” from it and a movement into the betwixt and between phase where the revised view of the RN role facilitated transitions. It resulted in shock that the old role did not automatically ease the transition process. Perhaps role change shock, as Gerrish (2000) suggested of the shock experienced by newly qualified nurses, is an inevitable result of the inability to be exposed to the realities of a role until it is taken up.

#### **7.4.3 Learning the part**

Learning the part is concerned with students learning performances which over time increasingly satisfy audiences of their potential to become an RN. It is characterised by the betwixt and between state and, as the model indicates, this is a dynamic process. The first meaning of the word “person” is mask (Park 1950). As Park suggested, it is a recognition that everyone is always and everywhere more or less consciously playing a role. It is in these roles that we come to know ourselves and each other and the mask represents the conception we have formed of ourselves

(Park 1950). In this study it was found HCAs began to see themselves as students striving to acquire the student mask in preparation for the RN role.

Learning the student part and acting it out convincingly involved three overlapping role performances and successfully negotiating their associated rites of passage: clinical; professional; academic. These were elements were found in Themes 3 and 4 and together culminate in “reconstitution” (Theme 5) when the individual is deemed suitable for inclusion in the register of nurses. The model from the present study presents these elements towards to the “Learning the part” stage of the model. However, students may continue to re-vision roles and slide back into the HCA role, but can also move forwards into the student role and the betwixt and between stage, then back again.

### ***The clinical role***

Students in clinical placements worked to acquire the knowledge and skills of the RN in order to convincingly act out the student role. Their prior experience impacted on role acquisition and rites of passage were negotiated as studentship progressed.

### ***Convincing performances (confidence)***

According to Goffman (1959), a performer can be fully taken in by his own act and be sincerely convinced that the impression of reality he stages is the real reality. At the other extreme, when the individual has no belief in his own act and no ultimate concern with the beliefs of his audience, we may call him cynical. Further, Goffman suggests we can expect to find natural movement back and forth between cynicism and sincerity along a continuum. The findings from this study suggest that students sought to become “sincere” performers, confident within themselves and able to demonstrate to audiences the requirements of the student role and the potential to become an RN.

Students attempted to influence their audiences, their assessors, which included most importantly mentors but also patients, to judge the situation in a particular sort of way. They needed a favourable judgement since they were required to “pass” each practice placement before they could move onto the next. However, they may not have felt completely confident in the judgement, favourable or otherwise, and the impression fostered during their performance. For



example, the survey recorded high clinical and professional confidence levels across the programmes when students were filling in the questionnaire and thinking in the abstract about nursing situations. However, these students with prior work experience were aware of the real world of nursing practice with all its uncertainties and contingencies and audiences who needed convincing of the part being staged. The survey recorded students' confidence as low in passing at placements at first attempt. Interview data confirmed this finding and the movement back and forth on a continuum from cynical to sincere performances characterises the betwixt and between stage of transition with all its discomforts and uncertainties.

### *Rites of passage*

The qualitative and quantitative findings together indicated that developing a knowledge base was seen by performers and audiences alike as a key way for students to move away from the HCA role, facilitate convincing performances and pass assessments. Rites of passage were described by van Gennep ([1909] 1960) as the customs and ceremonies whose structure and function mark the transition from one status or role to another. In this study rites of passage included formal assessments and informal experiences such as debasement activities and making work.

Interview data found a key strategy to develop a knowledge base was to ask questions in practice about practice. Other techniques employed by students were: reading books and journals, accessing information on the internet and reading information available in practice areas such as policy documents, wall posters and notices. This range of techniques facilitated disconnecting from the HCA role and movement through the betwixt and between stage. Students needed to become sincere performers who could demonstrate acquisition of the knowledge needed for inclusion into the target role. The survey found that after their first placement 59% of students agreed their knowledge base had increased and by the third year 92–94% agreed. The trend towards increased knowledge marks an important element in the transition process.

### *Debasement activities*

Interviews found evidence that mentors and other practitioners sometimes demeaned students in front of patient and staff audiences. These activities can be viewed as rites of passage. For example, a senior student who already possessed a first degree explained how he was mocked by his mentor in front of patient and staff audiences for his lack of knowledge about specific

medicines. During the betwixt and between state of transition Pascale (1984, p. 30) catches the essence of this mentor/audience perspective: "You may know a lot, but as far as this organization is concerned you are in kindergarten". Goffman (1959, p. 66) suggests that if symbols of status such as academic achievement are viewed grudgingly, "we are always ready to pounce on chinks in his armour to discredit his pretensions". Clinicians, such as the mentor quoted above, may be unimpressed by students' existing academic achievements and be looking out for chinks in their armour. This adds to students' difficulties in putting on a convincing performance. Moreover, to add to their discomfort, during interviews students explained they felt they were under constant surveillance by mentors and other practice assessors. Trice and Moreand (1989) suggest that debasement experiences are characteristic of workplace rites of passage. They can be seen as reinforcing the need to abandon the old role and responses and take up the new role and responses, but interviews indicated they were not viewed by students as facilitators of transitions.

#### *Make work*

One aspect of performance that has been studied in social establishments is called "make work" (Goffman 1959, p. 112). This examines how workers, in addition to producing a certain amount after a certain time, must also be prepared, when required, to give the impression that they are working hard at that moment. In this study evidence of make work was found. Students commented that they felt constrained in their learning and unable to read up on patients' care even when the work tasks had been completed. Melia (1987) noted almost 30 years ago that nursing is construed as work to be done and there is evidence from interviews that today reading is not construed as a legitimate work activity.

Students have to learn to negotiate their status as supernumerary students to meet the expectations of staff. Allen *et al.* (2011) suggest that in spite of supernumerary status students are expected by practice staff to do the work as well as learn. This is at odds with the "theoretical/academic" view of students' status and according to Allen *et al.* (2011) results in a hidden curriculum and a disintegrated learning environment. The findings from this study accord with Allen *et al.*'s (2011) explanation, particularly in early parts of programmes when students were striving to learn how to act out the student role. Students found they must negotiate the supernumerary theory/practice gap and its resulting discord and dilemmas. Goffman (1959) suggests, in general, when actors present their performances to audiences these tend to

incorporate and exemplify the values of the society they aspire to join. Making work, or “looking busy”, as students described it, was required to gain approval from the audience they aspired to join and a part of their rites of passage.

*Impact of prior experience: staff expectations*

Students found clinical staff assumed that their prior HCA experience would facilitate the transition to RN and expected good clinical skills, better than those of other students. Students also feared being consigned forever to the HCA role and being unable to extricate themselves. These perceptions created the dilemma for students of whether or not students admit their prior experience to clinical placements. Seconded students may have found it more difficult to hide prior experience because it was a prerequisite for the Lombard pre-registration programme. Nonetheless, they were still afforded the opportunity in new placements to be reticent about the nature of their prior experience. According to Goffman (1959), to execute a suitably sincere performance is a delicate thing and very minor mishaps can shatter the impression intended to be fostered (Goffman 1959). Moreover, audiences can orientate themselves to interactions by accepting performed cues on faith. Thus, insincerity or even misrepresentation could be imputed by audiences of mentors if the performer, the student, tried unsuccessfully to hide cues. These may have been difficult to hide, such as the ability identified by former HCAs to communicate easily with patients.

Discussing prior experience with clinical staff may help students make sense of their role and facilitate transitions. According to Nicholson and West (1989), sense making occurs during the “encounter” stage of work role transitions and prior to the next stage, adjustment to the role. Encounter involves affect and sense making during the first days or weeks of tenure and adjustment involves subsequent personal and role development to reduce the person/job misfit, as discussed in Chapter 2. The adjustment stage also involves the person developing the role to reduce person/job misfit. However, students are not in a position to do this, even by the end of three years’ studentship, and it is unlikely that neophyte RNs can do this either (Boychuck Duchsher 2008). Nicholson’s model of transitions and in particular the adjustment stage may fit better with experienced nurses who can, and do, develop and redevelop nursing roles (Barton 2007, Brown & Olshansky 1997, Sullivan-Benz 2010).

Unfortunately for students, “a single off key note can disrupt the tone of an entire performance” (Goffman 1959, p. 60), adding to the difficulties of the betwixt and between stage. Off-key notes are incompatible with the impression the performer wishes to convey and can be placed into three rough groupings: muscular control; conveying too much or too little concern; the setting (Goffman 1959). The muscular control needed to perform skills may have been affected by students’ fears that they had formerly been taught skills incorrectly and staff expectations of them were high. Displays of too much or little concern may also be problematic for former HCAs. They may have acquired behaviours unacceptable in a different setting. For example, Tanner and Timmons (2000) describe the familiarity of interdisciplinary staff interactions in operating theatres which may not be appropriate in other settings. The setting too can disrupt a performance and former HCAs may be only too aware of the many clinical contingencies which can disarrange it before or during the performance. However, what is required is that the student performer learns enough pieces of expression to fill in and manage, more or less, any part they are likely to be given. However specialised a routine, whatever the setting a student may rotate through, it will tend to claim facts which can be “equally claimed and asserted of other, somewhat different routines” (Goffman 1959, p. 36).

During studentship, particularly early in programmes, both the interviews and the survey found that prior work experience did not facilitate transitions when students were placed in unfamiliar practice settings. When the physical setting is different this alone can be off-putting (Goffman 1959), and Benner (1984) states that in a setting where the nurse is unfamiliar with the patient population, the tools of patient care and care goals, this limits the nurse to the novice level of performance. Benner’s work used the Dreyfus and Dreyfus model of skills acquisition based on chess players and airline pilots, and posits five levels of skills: novice, advanced beginner, competent, proficient and expert. In this study students reported they felt competent, perhaps proficient and some expert in their former role. This is characteristic of part-task systems wherein individuals practise particularistic skills frequently (Kramer 1974). Some former HCAs stated they “thought they knew everything”. Benner suggests it take two to three years in the same or a similar setting to become a competent nurse. Although not acting in the capacity of a nurse, perhaps it is not surprising that when students found themselves no longer competent or proficient or expert, but instead at the novice stage, or at best advanced beginner, this impacted on their confidence and negative feelings, stress and shock were experienced. Moreover, years

worked as an HCA and former workplace were found to have no statistically significant effects on clinical and professional confidence measures. As Benner (1984), Kramer (1974) and Goffman's (1959) analyses suggest and these findings confirm, prior work role experience does not guarantee a comfortable or strong starting point in a new setting. This was also found by Dearnley (2006) of Enrolled Nurses converting to RN. She reported that prior experience and competence does not readily transfer into a new role and environment.

### *Bad habits*

Being an experienced worker brought with it fears, real or unfounded, adding to the difficulties of the betwixt and between stage. During interviews students expressed fear that in their former role they may have been taught clinical skills poorly or incorrectly, but did not give examples of poor or bad practice, perhaps for fear of recrimination or reprisal. The survey showed that across cohorts there was agreement that some clinical skills had been lost, but it is possible these may have been skills not approved for student nurses to perform. However, the survey also found an upward trend in students agreeing that they had increased their range of clinical skills. This culminated at the end of the programme with 92% agreement and marks movement through the betwixt and between stage to inclusion into the profession and gaining the skills for whole-task analyses (Kramer 1974).

### *Backsliding*

Given the difficulties of transition it is small wonder that from time to time students voluntarily slid back into the familiar HCA role. If a student is to maintain supernumerary status then during day-to-day clinical performance they will have to conceal or forgo actions of the HCA which are inconsistent with the ideal student status. Also, when the conduct is satisfying in some way it is sometimes indulged in secretly. In this way "the performer can have his cake and eat it too" (Goffman 1959, p. 50). Findings indicated that students retreated to their "comfort zone" – the role of the HCA – and did so voluntarily, perhaps secretly, not primarily for the love of it, but when feeling overwhelmed by the student role. Brennan and McSherry (2007) also found voluntary retreat to the HCA role and argued that the comfort zone provided a place of shelter from where to start a clinical placement. However, the qualitative and quantitative data from this study shows that prior experience and its values and behaviours are not automatically transferable to students' placements. A place of shelter may not be readily apparent to students.

### *Wearing two hats*

Almost 77% of students were found to work as an HCA during studentship and interviews indicated that students perceived working as an HCA during studentship to be largely a benefit. Survey findings reported that working afforded greater financial security and interviews indicated that this did not cause role boundary confusion. This finding is in contrast to Holland's (1999) suggestion that the transition to nurse could be perpetuated by students taking up the dual role of HCA and student. Moreover, this study found that working during the programme was viewed as providing increased exposure to clinical practice and to practitioners, which facilitated the student role. Goffman (1959) suggests that the capacity to switch roles easily is one which everyone can apparently do, because once schooled in a part we are in a position to contrive a showing of it later. Students in this study quickly became clear about the boundaries of the two roles and moved between them easily. However, they explained that when wearing the HCA hat they did not give an entirely sincere performance. They performed the tasks and duties of an HCA but did so feeling and often acting like a student nurse. They said they could not divest themselves of the student role and used their time as an HCA to learn more about clinical practice. The survey also found that working as an HCA during the programme was statistically significant at Time 1 Year 1 with respect to academic confidence. This was also the time students felt most stressed and harboured negative feelings about clinical practice. The beginning of programmes is therefore a time of great upheaval for students in both the clinical and academic segments of studentship. Moreover, acting as a student when working as an HCA signals disconnecting from the old role or ending (Bridges 2009) or separation (van Gennep [1909] 1960) while the betwixt and between state was being played out. It demonstrates that the disconnecting and betwixt and between stages are overlapping strata wherein there is no sharp and clearly defined moment when movement from one stage to the next takes place. The period of transition is therefore fraught with difficulties. It is a betwixt and between state during which the student is marginal and orientating to new ways of working. It is a state of "self-distanciation", a process by which the persons come to feel estranged from themselves (Goffman 1959, p. 87), with students reporting no longer feeling comfortable in their role.

By the end of studies quantitative findings showed that clinical confidence was high, indicating students had learned at the least how to perform adequately. However, former HCAs must not

only be able to perform skills “correctly” (and attain academically), but must also learn the act of the “professional”.

#### **7.4.4 Professional performances**

Learning the student role required learning how to put on a professional performance as well as learning clinical skills. Theme 3 demonstrates how these two aspects of learning to be a nurse are intricately interwoven. Students spoke of both at one and the same time when discussing clinical practice. However, the model of transition presented in this chapter presents the two aspects separately for the purposes of theoretical analysis of the transition process. As with the other elements in the model there is recognition of the interplay between them, and perhaps there is no greater interrelationship than between the clinical and professional aspects of role performance.

In this study the professional element was found to include the appearance, manner or demeanour of the RN. Individuals’ “ceremonial behaviour” (Goffman 1956, p. 489) conveys to audiences through deportment, dress and bearing that they are a person of desirable qualities. Moreover, a desirable “front” (1959, p. 32) needs to be projected for a convincing performance to take place. “Front” functions in a general and fixed way to define the situation for audiences and consists of the “setting” and “personal front” (Goffman 1959, p. 32). The setting involves furniture, décor and physical layout and was discussed above in relation to its impact on performance and how it can become disarranged. Personal front consists of the appearance and manner of the performer.

Appearance includes the “carriers” or “sign vehicles” which function to reveal social status (Goffman 1959). During interviews students talked about feeling different and being treated differently by members of staff when they put on their student nurse uniform. This sign vehicle was, and is, a highly visible and material part of the custom and ritual of being a student nurse, marking disconnection from the old HCA role. It conveyed information to audiences of staff and patients of the status change of an individual undertaking a journey of transition (van Gennep [1909] 1960).

Manner consists of stimuli which warn us of the interaction role the performer will expect to play in the oncoming situation (Goffman 1959). In this study interviews indicated that the manner or

demeanour of the RN was difficult to pin down precisely, but the HCA manner and demeanour may not fit with the student role. For example, students realised they needed to become assertive and independent learners to move away from the passive HCA role where asking questions was frowned upon. They also struggled to overcome the dilemma of needing to prioritise clinical learning experiences above the immediate clinical needs of patients, which were often clearly and painfully apparent to them as experienced workers.

The difficulties of projecting a professional front were compounded by “meagre stage directions” (Goffman 1959, p. 79), which are common when role learning. This is borne out by the survey, which found students were often unclear of what was expected of them in clinical practice. However, interviews indicated that staff expectations of students were high. Audiences expect that those with experience already possess knowledge of how to manage voice, face and body, although both audience and performer may find it very difficult to identify and articulate exactly what constitutes this type of knowledge (Goffman 1959). This study found that students endeavoured to identify and learn what these were and the differences between the voices, face and body performances of RN and of the HCA. The survey found a significant relationship between professional confidence and positive feelings at the end of Years 1 and 2, perhaps reflecting that successful completion of each academic year was an important rite of passage.

A key technique for learning the student role, both clinical and professional aspects, was found during interviews to be observing RNs. Students needed to divest themselves of those aspects of performance learned as an HCA which did not signify the student/RN role. HCAs gradually found that former interpretations of the interpersonal cues and value systems were different from those in the RN community, adding to their role change shock. Communication skills serve as an example. Qualitative findings indicated that students believed their existing communication skills were good and they felt confident when speaking to the patient audience. However, students also came to recognise that their approach needed refinement and development. This was exemplified by the student who recalled routinely calling patients “darlin” when she was an HCA, failing to respect how the patient wished to be addressed. But it was not just what was said but how it was said that she came to see required change. She verbally demonstrated during the interview how as an HCA she had addressed patients loudly and nonchalantly, but as a student deemed this inappropriate.



The difficulties associated with meagre stage directions may also have been compounded by the ease with which seasoned performers unthinkingly carry off an act. This does not mean that the performance has not occurred, but merely that participants may not have been aware of it (Goffman 1959). In this study students were aware of the NMC standards of conduct for a professional nurse but were grappling with the meagre stage directions available in clinical practice to learn how to play it out. Benner (1984) suggests the expert nurse has an intuitive grasp of each situation and operates from a deep understanding of a total situation, which includes professional conduct and deportment, so describing an expert performance is difficult. Even the less than expert nurse, the proficient nurse, perceives situations as wholes and the perspective is not thought out but “presents itself” (Benner 1984, p. 27). It seems unlikely then that a professional manner could be easily articulated and made evident to students. In addition, at the outset of studentship students recorded that they did not understand the issue of accountability. It was not until they became a student that the extent of what practising accountably means became evident to them. However, surrounded by seasoned performances of RNs who unthinkingly act out the role with ease, it may simply not have been evident to HCAs. As students suggested during interviews, this lack of awareness may have been compounded because as HCAs they reported they were left alone to get on with their work, largely unsupervised by RNs. This was also found by Spilsbury and Meyer (2005) who in addition found that there are limited mechanisms available for communication between HCA and RNs.

Perhaps it is unsurprising that being placed in a different setting, projecting a new status in a different uniform, receiving meagre stage directions on how to interact “professionally”, high staff expectations and becoming professionally accountable, that students found the transition to studentship challenging. This was particularly evident early in programmes and compounded by students’ own expectations that prior experience would enable easy transitions.

#### **7.4.5 Academic performances**

The third element located towards the “learning the part” section of the model is concerned with learning how to perform in the academic role. The qualitative data indicated that the academic role could be tolerated rather than embraced, but students recognised its significance if their goal of professional inclusion was to be attained. The quantitative data confirmed its perceived

importance, with over 90% of students recording that it was an important or very important reason for wanting to be a nurse. Licensing bodies such as the NMC reinforce an ideal impression, a kind of rhetoric of training which:

requires practitioners to absorb a mystical range and period of training, in part to maintain a monopoly, but in part to foster the impression that the licensed practitioner is one who has been reconstituted by his learning experience and is now set apart from other men (Goffman 1959, p. 55).

Students recognised that they were required by the licensing body who oversee the RN “monopoly” to successfully perform academically. They desired academic education and the knowledge it bestowed as a marker to set them apart from “unqualified” health care workers and facilitate inclusion into the professional body of nurses. It was also needed to acquire the knowledge and skills for whole-task performances characteristic of the RN. The NMC stipulates the academic level required for entry to the profession, including a minimum of three years in the learning experience, to set them apart from other men and women. Kramer (1974) indicates that the scope of knowledge and skills required for whole task orientation takes considerable time to acquire, and is usually acquired in an institution of education. Former HCAs become university students and spend three years (full time) in practice and at university learning “universalistic” rather than “particularistic” skills, including academic skills, which can be used in a variety of situations.

During interviews, particularly early in programmes, students expressed fear of failure, in particular academic failure. The quantitative data shows academic confidence lowest at the beginning of programmes and highest at the end, but the end of Year 2 was also a low point. The low levels of confidence during programmes are perhaps unsurprising since if they are unable to attain the required academic standard, no matter how competent and confident in clinical practice, the student may not register as a nurse. Also, at early stages in programmes interviews found that students’ perceptions of what it meant to be a university student were at odds with the reality they experienced. This added to their role change shock and mirrors the finding that perceptions of the HCA and RN roles were deemed faulty once studentship commenced. Moreover, the survey found that when asked how difficult it was to adjust to being a student in the university, numbers who never found it difficult to adjust ranged from 41% at the beginning of Year 1 to 57% at the end of programmes. However, this also indicates that a large percentage of students found the

adjustment sometimes or always difficult and reflects the uncomfortable nature of the betwixt and between stage of academic role achievement.

Strategies were developed by students to facilitate academic achievement. To a large extent these mirrored those adopted in clinical practice, including developing reading skills and utilising the internet and electronic databases. However, interviews also found that students came to recognise they needed to concentrate and focus to be successful academically. Unlike clinical practice time, university academic learning time was not closely monitored. Students had to learn to be self-directed and manage their academic time effectively. In this respect the clinical and academic student roles were at odds with one another, adding to the difficulties of the betwixt and between stage. Students recognised that lecturers and practice facilitators were able to support academic development just as they sought out practitioners in clinical settings who could facilitate their development.

Getting to grips with the academic role was influenced at the start of programmes by students continuing to work as an HCA. Descriptive statistics showed that at Time1 Year 1 academic confidence was at its lowest and GLM testing indicated that continuing to work as an HCA was also statistically significant at this time when compared with other groups. Descriptive statistics also recorded that positive feelings were lowest at the beginning of studentship, and during interviews students explained they were anxious and uncertain about their academic abilities. Together these findings suggest that the start of studentship is challenging as students begin to disconnect from the old role and the betwixt and between stage begins.

Academic confidence increased as studies progressed, as might be expected, and descriptive statistics show confidence was highest at the end of programmes. GLM tests found a statistically significant relationship between the CLE and academic confidence at the start of Year 1 and throughout Year 2. The GLM parameter estimates showed no trends over time (Appendix 7.2) and, as noted above, the significant results may be explained as an artefact resulting from multiple testing. Interviews indicated that it was not until Year 3 that students began to see the relevance of theoretical perspectives to their clinical practice. The betwixt and between state of academic uncertainty persists until latter parts of programmes. However, the survey also showed that stress was also significantly high at the end Year 3. This perhaps reflects the significance and

importance of the final assessments as rites of passage, and of the prospect of imminently becoming a professionally accountable RN (Holland 1999, Brennan & McSherry 2007).

#### **7.4.6 Reconstitution**

The term “reconstituted” presented in this model is borrowed from Goffman (1959, p. 55) and is in tribute to him. It is preferred to others because it neatly epitomises the student experience presented in this study. Goffman (1959, p. 55) suggests “the licensed practitioner is one who has been reconstituted by his learning experience and is now set apart from other men”. This study found that students were indeed “reconstituted”, not only clinically, professionally and academically but also personally. Moving from the HCA to student role was found in both qualitative and quantitative data to include clinical, professional and academic development and the interviews also found that personal change and new re-visioned ways of seeing the world were experienced. According to Glaser and Strauss (1971), this multiplicity of status changes is a characteristic of the process of transitions.

The changes students experienced found were particularly evident during Year 1 but continued throughout studentship. A marker of increased professional confidence was found at the end of Year 1 and again at the end of Year 2. These perhaps reflect successful completion of key stages of programmes. Moreover, it was found that students’ positive feelings were statistically significantly different at the end of Year 1 when compared with the other groups. This perhaps reflects successful completion of the Common Foundation Programme at the end of Year 1. This was a rite of passage which incorporated students into a new status group, into the Adult Branch of nursing and into their chosen pathway to professional registration. Positive feelings were also significantly related to professional confidence at the end of Year 2, reflecting completion of two-thirds of studies. The confidence scales in the survey, clinical, professional and academic, indicated that these measures were statistically significant at the end of studies when compared with all other times. By the end of Year 3 interviewees said they felt they had moved from being an experienced worker to becoming a professional nurse and in so doing had become a more mature person. In their final management placement at the end of Year 3 they were able to demonstrate a whole-task performance needed for the total job (Kramer 1974). They felt they were ready and worthy of the RN role status, just as Merton (1957) found over 60 years ago of

medical students who over time came to think, act and feel like a physician and worthy of the status.

The status, then, of being an RN is not a material thing to be possessed and displayed, but instead is a “pattern of appropriate conduct, coherent, embellished and well articulated” (Goffman 1959, p. 81). It is not a matter of attaining a certificate of academic or clinical competence or of wearing a qualified nurse’s uniform. To become a nurse requires former HCAs perform in a manner befitting the role of the RN by the end of their three-year prescribed transitional period. They must leave behind a task-focused orientation characteristic of part-task work systems and fulfil the demands of a whole-task system. As the survey and interview data indicated, adjustment to the clinical role continues up to the end of the programmes. The transition experienced is a non-reversible process as individuals learn to perform in particular ways and to be a particular sort of person. They need to disconnect from the HCA role, experiencing the betwixt and between stage and successfully negotiating its rites of passage before inclusion into the professional body of nurses. They become “sincere” performers because, as students said, not only had their view of nursing practice changed but they had inwardly changed too. It is in roles that we come to know ourselves and each other, and the mask, as noted above, represents the conception we have formed of ourselves (Goffman 1959). This mask is the truer self, the self the student would like to be and in the end it becomes second nature and part of the person (Park 1950). The experienced worker becomes a professional; the student becomes an RN and all that it entails.

## **7.5 Summary**

This study has examined the transition from support worker to becoming professionally qualified. The findings from the qualitative and quantitative data have together provided an arguably more complete understanding of the transition from HCA to RN than would have been possible using one approach. The process of transition has been conceptualised as one of disconnecting from the old work role, a betwixt and between stage of learning to act out the student role which in the end is deemed by audiences as deserving the award of inclusion into the professional body of nurses.

Students re-visioned roles – their former HCA role, and that of RNs and the practice milieu, marking disconnection from their former role. They experienced role change shock as they

unexpectedly found themselves unprepared for the clinical, professional and academic performances required of a student nurse. They found that clinical skills, values and attitudes acquired as a support worker did not inevitably transfer easily to studentship, nor ease their transitions, as they had expected they would. They began to recognise the importance of supervision and mentorship in facilitating successful transitions. They experienced a wide range of emotions across studentship and their peer group, family and friends gave support.

The betwixt and between stage of transition was marked by learning the student part and the clinical, professional and academic performances it required. Students found themselves betwixt and between roles, neither fully HCA nor fully RN. Learning the student part was fraught with difficulties as students struggled to learn the RN act from the limited stage directions available in clinical practice, and expectations of them were high. They were required to recognise cues, conducts and appearances of the RN. They were required to acquire universal skills to take forward to their next stage and act. They were required to move from a part-task, particularistic skills approach to a whole-task orientation. They needed to perform convincingly in order to pass the series of placements, their formal rites of passage to RN status. They revised and reviewed prior practice and adjusted it accordingly, including poor or bad practice previously learned. They were required to successfully negotiate formal rites of passage, the assessments in clinical practice and the university. They also experienced “debasement” activities and “make work” as informal rites of passage. On occasion there was backsliding into their old role, their comfort zone, when feeling tired and overwhelmed by the student role which required them to think about their performances, not just act. Also, on occasion they were involuntarily allocated the HCA role when a supernumerary student, but working as an HCA during programmes was not problematic, at least not for students who increasingly used it as practice learning time.

The academic role also had to be successfully performed. Academic achievement facilitated acquisition of the knowledge and skills needed to understand the total job in a whole-task system of working. As in clinical practice, a range of strategies were developed and people support accessed, to facilitate the transition process. Learning to be a university student and self-manage academic time was in contrast to the close monitoring experienced in clinical practice. Struggling to understand the relevance of theory to practice also characterised the betwixt and between stage.

Finally, passing through the betwixt and between stage with its associated rites of passage resulted in a reconstituted person, one who had acquired a new mask. Individuals changed not just clinically, professionally and academically but also personally. The support worker became reconstituted, a different sort of performer and a more mature person, one feeling ready for and worthy of taking up the role of the professionally qualified nurse. They became formally incorporated, as a final rite of passage, into the register of nurses.

### **7.5.1 The HCA to RN model summary**

The model presented (Figure 7.1) provides analytic framework to explain how HCAs learn to act out the role of student nurse and become an RN. The dramaturgical approach is framed within a theory of transitions which provides an analytical and contextual superstructure. Together these two complementary approaches offer an understanding and explanation of the transition from support worker to professional qualification. Disconnect, betwixt and between and inclusion explain the pattern of transition which students experience. The dramaturgical approach demonstrates how students learn to act out the student role. It shows how students experience the pattern of change, the impact on them, and the elements which can facilitate and constrain progress, including their prior work role. Two overlapping strata are presented in the model – re-visioning (which includes motivations, changing work role perceptions, role exchange shock and support for studentship) and learning the part (which includes clinical, professional and academic performances and reconstitution). These explain how students move from the role of HCA, its values and perceptions to the student and RN role and the whole-task work system. The process is a dynamic one and movement back and forth across the elements of the model occurs before final inclusion into the professional body of nurses.

## **7.6 Implications**

The implications of this study for education, practitioners and managers, policy, and future research are presented next.

### **Education**

1. This study found that former HCAs' perceptions of the HCA role and the RN role changed when taking up the student role. This implies that students could usefully be taught early in pre-

registration programmes about role differences and the implications for former HCAs, including assumptions that prior experience will automatically ease the transition to student nurse and RN. The HCA to RN model could be used to explain roles as well as to show how the process of transition has been found to unfold. An understanding of the transition process may help students to manage it, including challenging elements such as role change shock.

2. Students reported that as HCAs they had largely been left to carry out care unsupervised and did not feel confident that they had been taught clinical skills correctly. These findings imply that there is a need for delegation and management teaching to have a higher profile and sustained emphasis throughout in pre-registration nursing programmes so that as RNs they can manage staff appropriately. Ultimately, and importantly, this could improve the care and safety of patients when students become practising RNs. As the proportion of RNs to HCAs decreases (Health and Social Care Information Centre 2015), this is arguably an increasingly important recommendation.

### **Practitioners and managers**

3. Findings indicate that more opportunities are required in clinical practice for students to develop delegation and management skills and emphasis on these is needed throughout studentship.

4. The HCA to RN model can be used to support mentors in their important role as well as health care organisations who provide student placements. The model can enable them to tailor learning experiences and build supportive informed cultures. Recognising that prior experience does not automatically facilitate the transition to student nurse could increase understanding and might also relieve students' dilemma of whether or not to admit to prior experience.

### **Policy**

5. Present health care workforce policy promotes skills and movement up the career ladder (Skills for Health 2011). Additionally, HCA experience is currently being encouraged as a prerequisite for entry to pre-registration nursing programmes (Cavendish 2013). This study has shown, perhaps counter-intuitively, that HCA work experience does not automatically facilitate the transition to studentship and RN status. The model presented in this study could be used by policy makers to support their workforce policy decision making.



## **Research**

6. Research is needed to test the finding that prior experience does not automatically facilitate the transition to student nurse and RN. It could test student nurses with and without prior work experience to explore the advantages and disadvantages of both.

7. Future research could compare the experiences of students who enter pre-registration programmes through HCA bridging programmes and those with HCA experience who do not take part in these programmes.

8. Further research could compare the experiences of students with prior HCA experience in different branches of nursing.

9. Research could compare newly qualified nurses with and without HCA experience to identify whether former HCAs adapt more quickly to the RN role due to prior experience.

10. The model presented may be applicable to a range of support and assistant workers in fields other than nursing. Workers in health care employed at levels 2/3/4 (Skills for Health 2011), including those in Occupational Therapy, Diagnostic Radiography, Physiotherapy, Dietetics and Midwifery, could test the model. Additionally, the model might apply to other groups of support workers studying for other types of professional qualifications, for example classroom assistant to teacher (see Wilson & Bedford 2008) or police community support officer to police officer. Future research could test the model with these and other groups of assistant workers undertaking the transition to professional qualification.

## **7.7 Limitations**

A cross-sectional design was selected for this study and the limitations of this approach are outlined above (Chapter 4, Section 4.2), where it was suggested that, ideally, a longitudinal approach could enhance the results. Longitudinal panel and trend surveys can assess trends through responses provided on successive occasions and point to causality through incidence rates. However, causal relationships can be difficult to interpret when multi-factorial elements exist (Bowling 2014), as in this present study where many elements are inherent in pre-registration nursing programmes. The cross-sectional approach adopted herein is appropriate for

descriptive statistics and can point to statistical associations between variables, although is not able to establish a causal link between student characteristics and experiences.

The implementation of the study also places limits on it. The internal validity of the survey questionnaire and the interview topic guide were underpinned by constructs identified in the systematic literature review alongside recognised literature on transitions and nursing practice. Reliability of the internal consistency of scales and groups of questions in the questionnaire was assessed using Cronbach's alpha ( $<0.7$ ), and the three-point Likert scales provided a logical midpoint, less likely to lead participants to high or low scores (Bjorkstrom *et al.* 2006). Moreover, the structured and predetermined wording in the questionnaire itself provided a fair degree of reliability (Field 2009). However, high construct validity through factor analysis remains to be established. As noted above (Chapter 4), in this study it was assumed that all measurements were independent and that clustering effects could be ignored. In addition, participant numbers were not consistent between and across cohorts and larger numbers of participants and higher response rates might have provided opportunities for further statistical testing and strengthened the findings. Moreover, question 12 in the survey could have been excluded: "If you had an ideal nurse in mind at the beginning of the programme, to what extent have you achieved your ideal?: not applicable; not at all; to some extent; to a great extent." As perhaps should have been anticipated, almost 95% of students responded "to some extent," so the question was not analysed.

Response bias also limits this study's reliability and validity. Non-response bias limits the findings and conclusions drawn, since the students who took part in the survey were self-selecting. Their characteristics and experiences of studentship may have been different to those who chose not to take part. Of those who did take part in the survey, a purposive sample was selected for interviews. However, they too were self selecting as they could choose not to take part.

A number of other biases may also limit this study. Student respondents may have displayed selective memories in recalling past experiences of studentship and may also have chosen not to report information when requested.

There may also have been assumption or conceptual bias on the part of the researcher. Her prejudices may have influenced the interpretations of findings, though at each stage of the enquiry the researcher was mindful of the possibility and sought to address it through long and detailed examination of interview transcripts and questionnaires and adopting a questioning approach. The mixed methods provided some reassurance of interpretations and triangulation of findings, though this could merely confirm bias. Interviewer bias could have influenced respondents to answer in a certain way. Interviews can be a possible source of misinterpretation and, although none of the students in this study were personally known to the researcher, she did identify herself as a nursing lecturer. It is possible this may have influenced students' responses. The same may be true of the survey where, as in all self-reported approaches, there is a risk that respondents may have been inclined to give answers they thought were expected, rather than what they really believed and meant. On the other hand, knowing the researcher had a background in nursing and nurse education may have encouraged participants to be candid in their responses because they may have perceived she was someone who knew what studentship was really like. However, levels of practice were difficult to ascertain in this study, but minimally acceptable levels of practice were assumed because they were mentor approved and assured, regularly, and throughout studentship. In addition, the researcher was well versed in nursing and medical "speak", so for the most part did not have to grapple with understanding a strange language. Also, knowing nurse education enabled the researcher to negotiate access to students and have sufficient wit to know when and when not to approach gatekeepers and students.

Findings from this study are of former HCA Adult Branch students studying at two universities in three countries but in one nation state. This limits the extent to which generalisations can be drawn as they may not reflect other students in other contexts. Also, former HCAs who participated in both the survey and interviews were self-selecting, limiting the extent to which findings can be generalised. Statistically random sampling is needed to demonstrate causality to a wider population. Moreover, generalisability is a matter of fit between the situation studied and others in which one might be interested in applying concepts and conclusions (Parahoo 2006). The model presented in this study remains to be tested by others.

The decision not to include observations of students in university and clinical settings also limits the study, because students' perceptions of their own behaviours may be different from those of

other people. Also, stakeholders such as patients, mentors and educators were not included in this study because their experiences were not the main focus of this study. These may add insights into students' transitions and could be included in or become the focus of future research.

The model of transition presented in this study, like all models of transition, provides a general overview of the likely experience of transition which may not apply to every student's individual experience or to the social context in which they learn to be a nurse.

## **7.8 Contribution to knowledge**

This study has contributed to knowledge in four ways:

- 1 A substantive model of transitions has been developed grounded in the data integrating two theoretical and analytical perspectives derived from widely accepted sources. No previous studies of nurses' or other workers' role transitions have been found which combine transitions theory with the dramaturgical approach.
- 2 This study has gone beyond the existing literature to advance empirical knowledge of the transition from HCA to RN, and in doing so has increased the knowledge base available to students, clinicians, managers, educationalists and policy makers.
- 3 This study contributes to workforce policy development by demonstrating that prior experience, contrary to students' expectations and the assumptions of clinicians and policy makers, does not automatically ease transition and can constrain as much as facilitate the transition of HCAs to student nurse and RN.
- 4 Methodologically, the use of cross-sectional, sequential, mixed methods design has developed understanding of the entire transition process from support worker to professionally qualified person.

## **7.9 Conclusion**

This thesis explains the transition from support worker to professional qualification, using HCAs as the exemplar. It was found that students, clinicians and policy makers assume and expect that prior HCA experience facilitates students' pathway to RN. Findings indicate that the former role and workplace experience does not automatically facilitate change and transition. Students have to disconnect from their former work role with its old values and perceptions and take up new

approaches to nursing and nursing practice. The student/RN role is not only concerned with technical skills and, as noted above, HCAs may be trained to perform skills which student nurses may not. It is concerned with different ways of thinking and working, moving from a task-focused approach to a whole-task approach. Students experienced role change shock when they found that prior experience did not automatically equip them for their placements and could constrain as much as facilitate their transitions. They entered a betwixt and between stage of uncertainty and discomfort while learning to act out the student role to the satisfaction of audiences of practitioners, educationalists and patients. Students changed and developed, clinically, professionally, academically and personally, becoming a “reconstituted” person before inclusion in the profession. The combination of transitions and dramaturgical, theoretical and analytical approaches explains the pattern and experiences of transition.

The journey of transition cannot be reversed because, once trained and educated to be a nurse, the traits deemed desirable by the profession are made to “stick” and continue to exert their influence long after initial education (Glaser & Strauss 1971). The mask of the nurse becomes second nature and part of the person (Park 1950). The support worker becomes professionally qualified – the transition from HCA to student and neophyte RN is completed.

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## APPENDIX 3.1

### NURSES' WORK ROLE TRANSITIONS: QUANTITATIVE LITERATURE APPRAISAL AND DATA EXTRACTION FORM

BACKGROUND INFORMATION	
Review question	
Role change:	
Endnote reference: Yes	
Title:	
Author(s):	
Year:	
Journal:	
Volume:	
Issue:	
Pages:	
STUDY DESIGN	
Aim(s) of study:	
Setting	
Country	
ELIGIBILITY CRITERIA	
Inclusion criteria	
Exclusion criteria	
Sampling procedure	
PARTICIPANTS	
Total no. of eligible participants	
Number of surveys included in the analysis	
Age range	
Standard deviation	
Females	
Males	
Ethnicities	
Other demographic details (e.g. employment status, location)	

<b>QUALITY APPRAISAL</b>			
<b>Scope and purpose</b>			
Was there a clear statement of, and rationale for, research question/aims/purposes?	Yes	No	Unclear
Was the study thoroughly contextualised by existing literature?	Yes	No	Unclear
<b>Research design</b>			
Was the method/design apparent, and consistent with the research intent?	Yes	No	Unclear
Was the data collection strategy apparent and appropriate?	Yes	No	Unclear
<b>Sampling strategy</b>			
Was the sampling method appropriate?	Yes	No	Unclear
Was the sample appropriate?	Yes	No	Unclear
<b>Analysis</b>			
Was the analytic approach appropriate?	Yes	No	Unclear
Were the statistical methods described?	Yes	No	Unclear
Which tests were performed? (Were the findings significant?)			
Was there a clear statement describing how valid and reliable the measures are?	Yes	No	Unclear
What were the confounding variables?			
<b>Interpretation</b>			
Was the presentation of results clear and unambiguous?	Yes	No	Unclear
Was it clear how interpretation of results/tests led to conclusions?	Yes	No	Unclear
<b>Objectivity</b>			
Was researcher objectivity demonstrated?	Yes	No	Unclear
<b>Ethical considerations</b>			
Was sensitivity to ethical concerns demonstrated?	Yes	No	Unclear
<b>Relevance and generalisability</b>			
Is relevance and generalisability evident?	Yes	No	Unclear
Is there a clear statement of findings?	Yes	No	Unclear
<b>QUALITY SUMMARY SCORE IN LIGHT OF THE APPRAISAL ABOVE (please tick one)</b>			
High			
Medium			
Low			
<b>FINDINGS OF INTEREST</b>			
Main findings			
Other findings			
<b>Key conclusions as reported by authors:</b>			

Adapted from: Long A.F., Godfrey M., Randall T., Brett A. & Grant M.J. (2002)

## APPENDIX 3.2

### NURSES' WORK ROLE TRANSITIONS: QUALITATIVE LITERATURE APPRAISAL AND DATA EXTRACTION FORM

BACKGROUND INFORMATION				
Review question:				
Role change:				
Endnote referenced:				
Title:				
Author(s):				
Year:				
Journal:				
Volume:				
Issue:				
Pages:				
STUDY DESIGN				
Aim(s) of study:				
Setting				
Country				
Sampling procedure				
Inclusion criteria				
Exclusion criteria				
Data collection methods				
Data analysis procedure				
PARTICIPANTS				
Total no. participants				
Contacted for participation				
Eligible but did not take part				
Age range				
Demographics				
QUALITY APPRAISAL				
Scope and purpose				
Was there a clear statement of, and rationale for, research question/aims/purposes?	Yes	No	Unclear	
Was the study thoroughly contextualised by existing literature?	Yes	No	Unclear	

<b>Research design</b>			
Is a qualitative methodology appropriate?	Yes	No	Unclear
Longitudinal	Yes	No	Unclear
Method(s)			
Data collection time phases			
Was the method/design apparent, and consistent with research intent?	Yes	No	Unclear
Was the data collection strategy apparent and appropriate?	Yes	No	Unclear
<b>Sampling strategy</b>			
Was the sample and sampling method adequately described?	Yes	No	Unclear
Was the sampling strategy justified?	Yes	No	Unclear
<b>Analysis</b>			
Was the analytic approach appropriate?	Yes	No	Unclear
Was there evidence of data saturation?	Yes	No	Unclear
Were deviant cases discussed?	Yes	No	Unclear
Was there evidence of member checking and/or independent analysis of data by more than one researcher?	Yes	No	Unclear
<b>Interpretation</b>			
Was the context described and taken account of in interpretation?	Yes	No	Unclear
Was there extensive use of field notes/quotes in discussion of findings?	Yes	No	Unclear
Was it clear how interpretation of data led to conclusions?	Yes	No	Unclear
<b>Reflexivity</b>			
Was researcher reflexivity demonstrated?	Yes	No	Unclear
<b>Ethical considerations</b>			
Was sensitivity to ethical concerns demonstrated?	Yes	No	Unclear
<b>Relevance and transferability</b>			
Is relevance and transferability evident?	Yes	No	Unclear
Is there a clear statement of findings?	Yes	No	Unclear
<b>QUALITY SUMMARY SCORE IN LIGHT OF THE APPRAISAL ABOVE (please tick one)</b>			
High			
Medium			
Low			
<b>FINDINGS OF INTEREST</b>			
Main findings:			
Supplementary findings			
<b>Key conclusions as reported by authors:</b>			

Adapted from: Walsh D. & Downe S. (2005)

### APPENDIX 3.3

#### SUMMARY OF QUALITY ATTRIBUTES AND CRITERIA

Attribute	Criteria
1. Study design (i) Appropriateness of study design	Aims, scope and purpose, eligibility criteria, approach appropriateness, contextualised by literature, method and data collection appropriateness
2. Sampling procedure (ii) Suitability of data collection strategy, and (iii) Appropriateness of sample and sampling method	Appropriateness and strategy justified
3. Analytic approach (iv) Appropriateness of analytic approach/tools	Appropriateness and evidence of data saturation, deviant cases and member checking and or independent analysis of data by > one researcher (QUAL studies) OR appropriateness, statistical methods and tests and confounding variables (QUAN studies)
4. Interpretation (v) Level of control over confounding variables, quantitative studies, or level to which the research context was adequately considered in qualitative studies	Context taken into account and evidence of field notes/quotes (QUAL studies), clear and unambiguous results (QUAN studies) AND how interpretation led to conclusions
5. Objectivity/reflexivity (iv) Appropriateness of analytic approach/tools	Researcher objectivity (QUAN studies) OR researcher reflexivity (QUAL studies)
6. Ethical considerations	Sensitivity
7. Relevance and generalisability vi) Whether interpretation of findings was justified by the data	Evident and clear statement of findings

## APPENDIX 3.4

### QUALITY ASSESSMENT SUMMARY (N=27)

Author(s) and year of publication	Role change and location	Aim of study	Design, methods and number of participants	Summary of findings	Quality findings	Quality rating
Barton T.D. (2007)	Experienced to specialist nurse (Wales)	To investigate the perceptions and educational experiences of nurse practitioner students	Ethnography Semi-structured interviews at beginning and end of 2-year programme and field notes throughout. Participants n=21 Comparative content analysis	Five transitions themes: social; professional; clinical authority; clinical knowledge; clinical skills. Students experience a composite of social and cultural transitions. Three-stage process of transition reflecting Van Gennep's "Rites of passage"	Independent analysis of data unclear	High
Bjorkstrom M.E. Johansson I.S. Athlin E.E. (2006)	Pre-registration student to experienced Staff Nurse (Sweden)	To explore what it means to be a good nurse by following students for some years after graduation	QUAL survey findings Phenomenological hermeneutics Time 1: start of pre-reg. programme (n=164) Time 2: end of pre-reg. programme (n=123) Time 3: 3–5 years post-registration (n=77)	Four categories: Being a good nurse; To do good for others; Competence and skills; Professional courage and pride. The meaning of being a good nurse increased in complexity over time; professional awareness increased, especially to be competent and skilled	Criteria met	High

Bjorkstrom M.E. Athlin E.E. Johansson I.S. (2008)	Pre-registration student to experienced Staff Nurse (Sweden)	To investigate how baccalaureate degree nursing students conceive their professional self over time, by following them from being students to some years after graduation.	QUAN survey Parametric and non-parametric analysis  Time 1: start of pre-reg. programme (n=63) Time 2: end of pre-reg. programme (.n=124) Time 3: 3–5 years post-registration. (n=82)	Generally respondents rated their professional selves highly and rather stably over time on items related to humanistic values, practice, affective and social skills. Six of 19 items increased significantly during the transition from student to nurse. The rating of “Knowledge mastery” and “Desire to contribute to research” decreased over time after graduation. Gender, previous studentship in health care and participation in development or research influenced the results in some parts	Criteria met	High
Bombard E. Chapman K. Doyle M. Shippee-Rice R. Radius Kasick D (2010)	Experienced to specialist nurse (USA)	To explore the experience of four direct entry masters degree students making the transition to the new role of Clinical Nurse Leader	Action research Participants (n=4) Over 15 months; Reflective journals; notes from seminar discussion. Four analytic discussions	Dominant theme: what is a Clinical Nurse Leader (CNL); subthemes: coming to the edge; trusting the process, rounding the corner; valuing becoming. The analysis claims to confirm the value of the CNL as a new vision of nursing education and practice. A series of ladder steps describe the process	Reflexivity unclear	High

Boychuck Duchscher J.E. (2001)	Newly qualified RN (Canada)	To explore how five nurses perceived their first six months as professional nurses	Phenomenology Participants n=5 Semi-structured interviews within 2 months and 6 months later plus monthly reflective journals Constant comparative analysis	Three major themes arose: doing nursing; the meaning of nursing; being a nurse. Attitudes of staff and MDT problematic. . Issues in graduate nurse practice identified at 1–3 months; 3–5 months and 5–6 months		High
Boychuck Duchscher J.E. (2008)	Newly qualified RN (Canada)	To provide a theoretical framework for newly qualified nurses to assist their transitions	Grounded theory Participants n=14 Interviews and focus groups 1, 3, 6, 12 and 18 months	New nurses feel anxious, insecure, inadequate and unstable in their work. By 12 months graduates had reached stability. A model of the stages of transition theory is presented building on 2001 study: doing; being; knowing	Criteria met	High
Boychuck Duchscher J.E.B Cowin L.S. (2009)	Newly qualified RN (Canada and Australia)	To offer a theory of transition shock based on cumulative knowledge from a programme of research	4 studies included: 1998: n=5, data collected over 6 months, phenomenological 2001: n=9, data collected over 12 months 2004: retrospective analysis of data collected in a 3-part study 2007: n=15, data collected over 18 months	Model of transition shock based on doubt, loss, confusion, disorientation; relationships, knowledge and responsibilities. Transition shock is presented as the most immediate, acute and dramatic stage in the process of professional role adaptation for the new nurse. Builds on Kramer's work on transition shock	Deviant cases discussions unclear; ethical considerations unclear	Medium



Brown A.M. Olshansky E.F. (1997)	Experienced to specialist nurse (USA)	To describe the experiences of new nurse practitioner graduates during the first year of primary care practice	Grounded theory. Interviews at 1, 6, 12 months 11 participants interviewed alone and 24 participants interviewed in 7 focus groups	A theoretical model of the process of transition from limbo to legitimacy is presented with four major categories Main themes: laying the foundation; launching; meeting the challenge; broadening the perspective	Criteria met	High
Cubit, K. Lopez, V. (2012)	Second to first level nurse (Australia)	To explore the transition experiences of graduate RNs who had previously practised as Enrolled Nurses	Descriptive qualitative method Content analysis Focus group discussions T1 (n=8) 1 week T2 (n=5) 6 months T3 (n=4) 12 months	Three categories: stepping out of comfort zone; being taken advantage of; needing support as much as others. Feared being judged as a capable RN once qualified due to prior experience	Criteria met	High
Dearnley C. (2006)	Second to first level nurse (England)	To examine the relationship of the mode of course delivery and the personal and professional development of experienced learners	Phenomenology Constant comparative analysis Semi-structured interviews 5x over 2 years. Total interviews n=58	Core category: finding a professional voice. Subcategories: hesitant, liberated and dynamic practitioner. A model is proposed. Changing ways of knowing impact on personal and professional change	Criteria met	High
Deasey C. Doody O. Touhy D. (2011)	Pre-registration student to RN (Ireland)	To explore the transition of one cohort who had substantial rostered practice during the final year of their programme	QUAN survey 6 months prior to registration and 6 months following registration	Expectations of feedback and support; confidence in clinical abilities; stress; participation in direct patient care	Criteria met	High

			T1 (n=116) 6 months prior to registration T2 (n=96) 6 months post-registration			
Etheridge S.A. (2007)	Newly qualified (USA)	To address the perceptions of new nursing graduates about learning to make clinical nursing judgements	Descriptive Phenomenological Interviews at end of preceptorship, 2–3 months after and 8–9 months after the first interview. Number of interviewees not given	Learning to think like a nurse. Unaware of level of responsibility; lack confidence in clinical judgements; confidence increases and ability to take responsibility and think critically. Support from faculty and peers essential to support the transition	Sampling strategy criterion not met; sampling justification criterion not met; analytic approach unclear; data saturation unclear; deviant cases criterion not met	Low
Fagerberg I. Elkman S.L. (1998)	Preregistration student to RN (Sweden)	To elucidate the experiences of students during three years in nurse education from the perspective of their experiences with elderly patients	Phenomenological/ hermeneutic approach, thematic analysis Interviews at the end of each academic year Interviews analysed (n= 27) Diaries analysed at end of years 2 and 3 (n=26)	Six themes identified in a continuous process and co-operation with other team members had a strong influence on student's identification as a nurse. Themes: self esteem; identification as a nurse; theoretical knowledge and technical skills; co-operation in health care team, caring for elderly patients; preceptor and educator support	Independent analysis of data unclear	High

Gerrish K. (2000)	Newly qualified (England)	To examine newly qualified nurses' perceptions of the transition from student to qualified nurse and compare these perceptions with those of nurses who qualified in 1985	<p>Study 1: 1985, University A Grounded theory In depth interviews (n=10) Constant comparative method of analysis</p> <p>Study 2: 1998 University B Grounded theory In-depth interviews (n=22) Constant comparative method of analysis</p>	Compares education pre- and post-PK200. Newly qualified in the second study still felt inadequately prepared for their new role though had developed a more active style of learning and preceptorship reduces stress. Transition to qualified nurse less stressful for 1998 group and the concept "fumbling along" (1985) no longer felt to the same extent	Criteria met	High
Glenn S. Waddington K. (1998)	Staff Nurse to Clinical Nurse Specialist (England)	To identify factors that facilitate and impede the transition from Staff Nurse to Clinical Nurse Specialist	Case studies (n=2) Taped supervision sessions; semi-structured group interviews; reflective accounts collected over one year	Dimensions of CNS roles: acting independently of superiors; setting work targets; choosing the order of parts of job performed; choosing with whom to deal. The transition from Staff Nurse to Clinical Nurse Specialist is always a challenge but Nicholson & West (1984) and Wanous (1992) models enable exploration of roles to carry out the job	Ethical considerations unclear	High

Godinez G. Schweiger J. Gruver J. Ryan P. (1999)	Newly qualified (USA)	To describe the initial steps in role transition from graduate nurse to Staff Nurse and identify learning strategies that educators can use to facilitate transition	Daily feedback sheets during first 3 weeks' orientation Orientees and preceptors (n=27) Content analysis	Five themes emerged: real nurse work; guidance; transitional process; institutional context; interpersonal dynamics. Initial transition of a graduate nurse was a dynamic and interactive process occurring between graduate and preceptor. Guided learning facilitated increasingly complex care and interpersonal dynamics with staff and preceptors affected the process	Field notes/quotes criterion unmet; ethical considerations unclear; transferability unclear	Medium
Holt I.G.S. (2008)	RN clinical role change (England)	To enable understanding of role transition from a study of community nurses going through changes to their roles or moving to new roles	Grounded theory Participants(n=11) Participant and non-participant observations; content analysis of job descriptions and group interviews	Theory to transition: who; what; where; how Four concepts: centring identities; focusing roles; enacting roles; shaping roles A model of transition is proposed for primary health care practitioners	Data collection time phases unclear; independent analysis of data unclear; ethical considerations unclear	High
Kapborg I.D. Fischbein S. (1998)	Newly qualified (Sweden)	To investigate nurses' experiences of the transition from the three-year nursing programme to a professional role as a nurse	Daily diary entries for 2 months Purposive sampling Participants (n=8) Content analysis of data	Difficulties relaxing off duty; high workload stressful; dissatisfied because did not master whole situation Problematic: management of paperwork	Criteria met	High

				Uncertain about care of patients with serious illness Difficulties delegating Difficulties knowing when to call physician Difficulties prioritising		
Melrose S. Gordon K. (2011)	Second to first level nurse (Canada)	To explore Post Licensed Practical Nurse to Bachelor of Nursing students' experiences during their education	Interviews, beginning, middle and end of 3-year programme. Thematic analysis Total participants n=10	Themes: 1. mentors helped students apply learning; 2. personal learning goals sustained motivation; 3. time management strategies included terminating full-time employment. Focus on barriers/facilitators to transition	Transferability unclear	High
Newton J.M. McKenna L. (2007)	Newly qualified Australia	To examine how graduate nurses develop their knowledge and skills during their graduate programme and immediately after; and to explore what factors, if any, assist or hinder graduate nurses' knowledge and skills acquisition	Focus groups 4–6 months; 11–12 months post-qualification and 4–6 months following completion of graduate programme Participants n=25 Colaizzi thematic analysis	Themes: 1. gliding through; 2. surviving; 3. beginning to understand; 4. sheltering under an umbrella; 5. knowing how to; 6. we've come a long way	Criteria met	High

Ross H. Clifford K. (2002)	Newly qualified (England)	To examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified practitioner To identify areas for discussion and development in both education and practice	Survey and interviews of one cohort pre-qualification and post-qualification Convenience sample T1 survey (n=19) T1 interviews (n=4) T2 survey (n=13) T2 interviews (n=0)	The transition remains very stressful for some nurses because of both pre-registration education issues and level of support once qualified. Careful planning of student experience in the final year and addressing inconsistencies in preceptorship programmes are needed	Analytic approach criteria unclear; data saturation unclear; deviant cases unclear; independent analysis unclear	Low
Roziers R.L. Kyriacos U. Ramugondo E.L. (2014)	Newly qualified (South Africa)	To explore the lived experience of role transition of newly qualified nurses undertaking a compulsory community service in health service facilities in the Western Cape	Phenomenology Semi-structured interviews T1 (n=8) before placement start T2 (n=8) 6 weeks into placement	Three themes: 1. a sense of achievement 2. uncertainty and fear in anticipation of reality 3. reality shock	Sampling strategy unclear	High
Rungapadiachy D.M Madgill A. Gough B. (2006)	Newly qualified (England)	To examine whether nurses have changed their perception of their role having had 6 months' post-registration experience	Grounded theory Semi-structured interviews T1 (n=14) pre-registration T2 (n=11) minimum of 6 months post-registration	Themes identified: transition; role ambiguity; lack of support; theory practice gap. T2: no drastic change in perceptions, the role of mental health nurse is ambiguous and participants more able to articulate rationales for practice vis-à-vis the clinical realities	Criteria met	High

Schoessler M. Waldo M. (2006)	Newly qualified (USA)	To present a process model to help new graduated nurses interpret their experience during the first crucial months in practice and assist organisations to provide support	Interpretative phenomenology Graduate nurses "met regularly" over 18 months for discussions in a "non-directed open-ended conversation" Data analysis "analysed for common themes/ perspectives"	Four themes: relationships with patients and families; organising for patient care; relationships with health care team; experience of marker events. Model proposed integrates three theoretical frameworks (Skills acquisition – novice to expert; Transition management; Experiential learning cycle)	Analytic approach unclear; data saturation unclear; deviant cases criterion unmet	Low
Seng J.S. Sanubol M. (2004)	Experienced to specialist (USA)	To learn what first year of sexual assault nurse was like in terms of role transition and role-specific stress	Focused ethnography and narrative analysis and content analysis Participants (n=6) Interviews beginning, middle and end of programme plus analysis of internal organizational documents	Five themes: transition to nurse practitioner role; contextual factors; inter-professional relationships; provincial politics and policies; educational preparation. Prior experience eased transition; role expansion rather than transition	Criteria met	High
Sullivan-Benz M. Humbert J. Cragg B. Legault F. Laflamme C. Bailey P.H. Doucetter S. (2010)	Experienced to Specialist (Canada)	To examine role transition and support requirements for nurse practitioner (NP) graduates in their first year of practice from the perspectives of	Focused ethnography and narrative analysis plus content analysis Telephone interviews	Theoretical framework taken from Brown & Olshansky (1997). Themes: role adjustment; contextual factors; inter-professional relationships;	Researcher reflexivity unclear	High

		NPs and co participants familiar with the NPs' practices and make recommendations for practice, education and policy	Nurse practitioners (n=23) Co-participants (n=21) Analysis of internal organisational documents	policy and politics; educational preparation Familiarity of colleagues and employers with role important. Lack of preparation, orientation, mentorship and awareness of role constrains transition. One third of participants left new role due to inter-professional conflict and lack of role recognition		
Walker J. (1998)	Newly qualified (New Zealand)	To describe the issues faced in the transition from student to beginning practitioner and to explore how the knowledge, skills and attributes developed during the degree programme and how they have helped or hindered transition. Transcripts member-checked and data analysed for categories and themes	Qualitative descriptive approach Purposive sample from one cohort Focus group, semi-structured interviews with same participants T1 (n=5) 4 months T2 (n=5) 9 months	Five themes emerged: accepting responsibility; accepting knowledge level; becoming a team member; professional standards; workplace conditions. Some knowledge gained was utilised, could self-critique but more difficult to challenge others and the wider organisation	Analytic approach unclear	High



**APPENDIX 3.5**  
**SUMMARY/MATRIX**

Author (year) Location	Role change	Design, methods and number (n) of participants	Summary of findings			
			Findings	Pathway	Aspects of transition codes: Perceptions and experiences	Aspects of transition codes: Facilitators and constraints
QUALITATIVE STUDIES						
Barton T.D. (2007) Wales	Experienced to specialist nurse	Ethnography Interviews x2 over 2 years Field notes (n=21)	Themes: social; professional; clinical authority; clinical knowledge; clinical skills Reflects van Gennep’s model – “Rites of passage”	Experienced nurse	Frustration Skills and competence Conflict Identity	Facilitators: role models and changing relationships with colleagues  Constraints: resistance and hostility from colleagues New role unacknowledged
Bjorkstrom M.E. <i>et al.</i> (2006) Sweden	Pre-registration student to experienced Staff Nurse	Phenomenology Survey x3 Pre-registration start (n=164); Pre-registration end (n=123); 3–5 years post-registration (n=77)	Categories: being a good nurse; to do good for others; competence and skills; professional courage and pride	Novice to experienced nurse (3–5 years post- graduation)	Reference groups Competence and skills Identity	Facilitators: personnel in the workplace are key for professional development
Bombard E. <i>et al.</i> (2010) USA	Experienced to specialist nurse	Action research over 15 months; reflective journals; notes from seminar discussion; analytic discussions (n=4)	Dominant theme: what is a Clinical Nurse Leader (CNL) Subthemes: coming to the edge; trusting the process, rounding the corner; valuing becoming	Experienced nurse	Frustration Identity	Facilitators: preceptors critical for success  Constraints: preceptors’ lack of understanding of the

						new role; lack of nursing experience; preceptors and faculty need closer collaboration
Boychuck Duchscher J.E. (2001) Canada	Newly qualified RN	Phenomenology Interviews at 2 and 6 months; journals monthly (n=5)	Themes: doing nursing; the meaning of nursing; being a nurse Staff attitudes problematic	Novice nurse	High levels of anxiety and stress Disappointment	Facilitators: mentors and HCAs; new graduate programmes; acceptance by colleagues; clinical competence  Constraints: poor staff attitudes and behaviours; lack of knowledge; lack of preceptor; fast environments; moving around clinical areas
Boychuck Duchscher J.E. (2008) Canada	Newly qualified RN	Grounded theory Interviews and focus groups at 1, 3, 6, 12 and 18 months (n=14)	New nurses feel anxious, insecure, inadequate and unstable in their work. By 12 months graduates had reached stability. A model of transition is presented	Novice nurse	Stress and anxiety. Fear of failure and disappointing family, friends and reference groups. Excitement at outset. Comfort and confidence Competence Identity	Facilitators: personnel in the workplace are key for professional development
Boychuck Duchscher J.E.B &	Newly qualified RN	Four studies included: 1998: Phenomenology – data collected over 6	Model of transition shock based on: doubt, loss, confusion, disorientation; relationships,	Novice nurse	Transition shock: doubt, loss, confusion,	Facilitators: mentors; NNG programmes; feedback; acceptance

Cowin L.S. (2009) Australia & Canada		months (n=5) 2001: data collected over 12 months (n=9). 2004: retrospective analysis of a 3-part study. 2007: data collected over 18 months (n=15)	knowledge and responsibilities		disorientation; physical, emotional, intellectual, socio-developmental	by colleagues  Constraints: lack of: support; experience; confidence; faculty support. Poor staff attitudes/behaviours; floating between units
Brown A.M. & Olshansky E.F. (1997) USA	Experienced to specialist	Grounded theory Interviews: individual at 1, 6, 12 months (n=11) Seven focus groups (n=24)	Main themes: laying the foundation; launching; meeting the challenge; broadening the perspective. Model of transition presented.	Experienced nurse	Anxiety, skills competence, confidence Identity	Facilitators: reduced workload; opportunities to develop skills
Cubit K & Lopez V (2012) Australia	Enrolled/Licensed Practical Nurse to RN	Descriptive, qualitative Focus groups x3 Week 1 (n=8); 6 months (n=5); 12 months (n=4)	Categories: stepping out of comfort zone; being taken advantage of; needing support as much as others. Feared being judged as a capable RN once qualified due to prior experience	Experienced nurse	Worry, anxiety, fear and discomfort. Skills	Facilitators: consistent mentoring; Graduate Nurse Programme  Constraints: being taken advantage of due to prior experience
Dearnley C. (2006) England	Enrolled/ Licensed Practical Nurse to RN	Phenomenology Interviews 5x over 2 years (n=58)	Core category: finding a professional voice Subcategories: hesitant, liberated and dynamic practitioner. A model of transition is proposed	Experienced nurse	Competence and skills, confidence Identity	Facilitators: developing reflective practice

Etheridge S.A. (2007) USA	Newly qualified	Phenomenology Interviews at end of preceptorship, 2/3 months and 8/9months following Numbers unavailable.	Main theme: learning to think like a nurse. Subthemes: developing confidence, learning responsibility; relationships with others, thinking critically	Novice nurse	Stress, confidence, boundary blurring and uncertainty Identity	Facilitators: support from faculty and peers; clinical experience  Constraints: insufficient autonomy
Fagerberg I. & Elkman S.L. (1998) Sweden	Pre-registration student to RN	Phenomenology Interviews at the end of each academic year (n=27) Diaries analysed at end of years 2 and 3 (n=26)	Themes: self-esteem; identification as a nurse; theoretical knowledge and technical skills; co-operation in health care team, caring for elderly patients; preceptor and educator support	Novice nurse	Stress and anxiety Skills competence, confidence Identity Reference groups	Facilitators: team acceptance and co-operation; leadership; acceptance by team; mentorship; educators/ theoretical knowledge; small group discussions; technical knowledge  Constraints: LPN power; poor mentors/preceptors; preceptors lacking time
Gerrish K. (2000) England	Newly qualified	Study 1: 1985, University A Grounded theory, interviews (n=10) Study 2: 1998, University B Grounded theory, interviews (n=22)	Compares education pre- and post-PK2000. Both groups felt inadequately prepared Transition to qualified nurse less stressful for 1998 group and the concept "fumbling along" (1985) no longer felt to the same extent	Novice nurse	Stress, shock Competence, confidence and skills	Facilitators: orientation programme; preceptor; supernumerary status; lifelong learning skills  Constraints: lack of clinical, management and organisational skills

Glen S. & Waddington K. (1998) England	Staff Nurse to Clinical Nurse Specialist	Case studies Taped supervision sessions; group interviews; reflective accounts collected over 1 year (n=2)	Dimensions of CNS roles: acting independently of superiors; setting work targets; choosing the order of work; choosing with whom to deal. Nicholson & West (1984) and Wanous (1992) transition models enabled exploration of roles	Experienced nurse	Stress and frustration Competence and skills Identity Boundaries	Facilitators: induction including professional, clinical and organisational aspects, time and stress management; clear role definitions and boundaries; effective inter-professional relationships; appraisal and supervision; CNS support network; clear career pathways and professional development  Constraints: resistance to change
Godinez G. <i>et al.</i> (1999) USA	Newly qualified	Descriptive, qualitative Daily feedback sheets during first 3 weeks of orientation Nurses and preceptors (n=27)	Themes: real nurse work; guidance; transitional process; Institutional context; interpersonal dynamics Model of transition presented	Novice nurse	Skills and competence Boundaries blurring and uncertainty Identity Reference groups	Facilitators: assuming activities of a Staff Nurse; preceptor's guidance and regular feedback; good workplace relationships  Constraints: lack of skills
Holt I.G.S. (2008) England	RN clinical role change	Grounded theory Participant and non-participant observations; job descriptions analysis;	Theory to transition: who; what where; how Four concepts: centring identities; focusing roles;	Experienced nurse	Identity Reference groups Boundaries Stress	Facilitators: mentors/preceptors  Constraints:

		group interviews (n=11)	enacting roles; shaping roles A model of transition for primary health care practitioners is presented			inadequate support; reduced resources particularly time; unrealistic expectations
Kapborg I.D. & Fischbein S. (1998) Sweden	Newly qualified	Qualitative constant comparative analysis Daily diary entries for 2 months (n=8)	Difficulties: relaxing off duty; high workload; dissatisfied; management of paperwork; patients with serious illness; delegating; knowing when to call physician; prioritising	Novice nurse	Reality shock, stress, dissatisfaction Skills, competence Identity Reference groups Time management	Facilitators: orientation programmes: staff support including experienced nurses and medics  Constraints: high workload, lack of time; lack of skills; gap between theory and practice of nursing
Melrose S. Gordon K. (2011) Canada	Enrolled/Licensed Practical Nurse to RN	Phenomenology Interviews: beginning, middle and end of 3 years (n=10)	Themes: mentors helped students apply learning; personal learning goals sustained motivation; time management included terminating full-time employment	Experienced nurse	Competence and skills Identity Stress	Facilitators: mentors; personal goals; time management  Constraints: relentless family and workplace demands
Newton J.M. & McKenna L. (2007) Australia	Newly qualified	“Qualitative” Focus groups x3 4–6 months and 11–12 months post-qualification (n=25)	Themes: gliding through; surviving; beginning to understand; sheltering under an umbrella; knowing how to; we’ve come a long way	Novice nurse	Stress, overwhelmed, Confidence and competence Reality shock	Facilitators: preceptor vital  Constraints: horizontal violence, bullying and bitchiness; clinical rotation programmes

Ross H. & Clifford K. (2002) England	Newly qualified	Qualitative Survey (free text only analysed) and interviews pre- & post-qualification T1 survey (n=19) Interviews (n=4) T2 survey (n=13) Interviews (n=0)	The transition remains very stressful for some nurses because of both pre-registration education issues and level of support once qualified	Novice nurse	Stress, fear of harming patients, anxious nervous and frightened Disappointed, dissatisfied, disillusioned Boundaries: blurring and uncertainty	Facilitators: team support; preceptor/mentor  Constraints: preceptor inconsistencies and lack of time/heavy workload; education insufficiently focused on skills and knowledge for practice
Roziers R.L. <i>et al.</i> (2014) South Africa	Newly qualified	Phenomenology Interviews x2 2 weeks before and 6 weeks after graduate community service placement (n=8)	Pre-placement: sense of achievement in having successfully completed diploma programme Post-placement: uncertainty, fear and reality shock	Novice nurse	Reality shock Uncertainty Fear	Facilitators: orientation programme; financial independence; time for family and friends  Constraints: unwelcoming colleagues; substandard clinical environment; staff conflicts; staff shortages; left alone to manage ward and high-acuity patients
Rungapadiachy D.M. <i>et al.</i>	Newly qualified	Grounded theory Interviews T1 pre-registration (n=14)	Themes: transition; role ambiguity; lack of support; theory–practice gap T2: no	Novice nurse	Frustration, Competence Boundaries' blurring	Constraints: feeling unprepared; role ambiguity; managers:

(2006) England		T2 6 months post-registration (n=11)	drastic change in perceptions		and uncertainty Conflict Reality shock	blame culture; negative attitudes to care; lack of resources; shortage of nurses
Schoessler M. & Waldo M. (2006) USA	Newly qualified	Phenomenology Graduate nurses "met regularly" over 18 months for discussions	Themes: relationships with patients and families; organising for patient care; relationships with health care team; experience of marker events. model of transition proposed	Novice nurse	Stress, anxiety, fear Skills competence Conflict Identity Shock	Facilitators: broadening perspective; comfort with skills and tasks; acceptance as a team member  Constraints: problematic relationships; boundary ambiguities; low staffing levels; personal stress
Seng J.S. & Sanubol M. (2004) USA	Experienced to specialist	Ethnography Interviews x3 over 1 year (n=6) Analysis of internal organisational documents	Themes: transition to NP role; contextual factors; inter-professional relationships; provincial politics and policies; educational preparation. Prior experience eased transition; role expansion rather than transition; stress not as great as anticipated	Experienced nurse	Stress not as great as anticipated Skills, competence	Facilitators: recognising prior experience very important; assisting others; rehearsing mentally; support by experienced person on first examination; first examination; positive feedback from victim; support of team members; debriefings; developing skills;



						<p>developing a routine; noticing similarities; training; formal feedback; team meetings</p> <p>Constraints: possible reprisal by perpetrator; working hours affect family life</p>
<p>Sullivan-Benz M. <i>et al.</i> (2010) Canada</p>	<p>Experienced to specialist</p>	<p>Ethnography Interviews x3 over 1 year Nurse practitioners (n=23) Co-participants (n=21) Analysis of internal organisational documents</p>	<p>Themes: role adjustment; contextual factors; inter-professional relationships; policy and politics; educational preparation Familiarity with reference groups, roles and employers important. One third of participants left new role due to inter-professional conflict and lack of role recognition</p>	<p>Experienced nurse</p>	<p>Stress, overwhelmed, Confidence Reference groups Boundary blurring and conflicts</p>	<p>Facilitators: experienced mentoring and co-participants, previous experience.</p> <p>Constraints: organisational and professional unfamiliarity with role. Lack of: orientation; educational preparation; time; reimbursement; formal feedback; role unrecognised in provincial and local legislation and regulations.</p>

Walker J. (1998) New Zealand	Newly qualified	Qualitative descriptive approach Focus groups with same participants: T1 4 months (n=5) T2 9 months (n=5)	Themes: accepting responsibility; accepting knowledge level; becoming a team member; professional standards; workplace conditions. Some knowledge was utilised, could self critique, difficult to challenge others and the wider organisation	Novice nurse	Stress and anxiety Skills Reality shock Reference groups	Facilitators: becoming a team member; preceptor programmes; orientation programmes; black humour; skills for practice  Constraints: inadequate staffing; lack of management support; poor practice
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QUANTITATIVE STUDIES						
Bjorkstrom M.E. <i>et al.</i> (2008) Sweden	Pre-registration student to experienced Staff Nurse	QUAN survey x3 Pre-registration start (n=163) Pre-registration end (n=124) 3–5 years post-registration (n=82)	Generally rated professional self highly and stably over time on items related to humanistic values, practice, affective and social skills. Six of 19 items increased significantly during the transition from student to nurse. Two items decreased after graduation: knowledge mastery; desire to contribute to research	Novice nurse to experienced (3–5 years post-graduation)	Increases in competence, skills , confidence Identity changes over time and prior experience can influence results	Facilitators: direct involvement in research may increase thirst for knowledge  Constraints: Lack of time, authority and support impacts on research awareness and utilisation
Deasey C. <i>et al.</i> (2011) Ireland	Pre-registration student to RN	QUAN survey x2 T1 6 months prior to registration (n=116) T2 6 months post-registration (n=96)	Expectations of feedback and support; confidence in clinical abilities; stress; participation in direct patient care	Novice nurse	Stress Competence, confidence	Facilitators: substantial rostered practice prior to registration; induction and orientation programmes  Constraints: expectations of formal support unmet; lack of access to educators for support

## APPENDIX 4.1

### QUESTIONNAIRE CASTLETON UNIVERSITY

Code no. \_\_\_\_\_



## From Health Care Assistant to Registered Nurse

We would like to invite you to participate in a research study of student nurses who have been formerly employed as HCA/assistant nurses. The primary aim of the research is to help us increase our understanding of the factors that enable and constrain your learning, and make recommendations to enhance further learning for students like you.

We would be grateful if you would complete the questionnaire which takes about 25 minutes. Throughout the questionnaire the abbreviation "HCA" is used to cover all assistant nurse roles. **There are no right or wrong answers** to the questions. It is your views and opinions we are interested in.

Please note that your responses will be treated in confidence and neither you, patient/clients, or colleagues, will be identified in publications that arise from this research. If you wish you can request a summary report of the research to be sent to you.

**Please complete this questionnaire by ticking the box that represents your answer.**

If, after completing these questions, you want to add some more information, please use the space provided on the back page.

## Section A: About yourself

- **What is your gender?** Male ☐ Female ☐
- **What was your age last birthday?** .....
- **What was your first language?** .....
- **What are your qualifications?** *Tick all that apply*
- |                          |                          |              |                          |
|--------------------------|--------------------------|--------------|--------------------------|
| GCSE (1-3) or equiv.     | <input type="checkbox"/> | NVQ          | <input type="checkbox"/> |
| A Level or equiv.        | <input type="checkbox"/> | First degree | <input type="checkbox"/> |
| Post grad. qualification | <input type="checkbox"/> |              |                          |
| Other                    | <input type="checkbox"/> | Details..... |                          |
- **What was the main clinical area that you worked in when you were an HCA?**
- | (A) Hospital       |                          | (B) Community    |                          |
|--------------------|--------------------------|------------------|--------------------------|
| Surgical           | <input type="checkbox"/> | Nursing Home     | <input type="checkbox"/> |
| Operating Theatres | <input type="checkbox"/> | GP practice      | <input type="checkbox"/> |
| Maternity          | <input type="checkbox"/> | Rehabilitation   | <input type="checkbox"/> |
| Outpatients        | <input type="checkbox"/> | Residential Home | <input type="checkbox"/> |
| Medical            | <input type="checkbox"/> |                  |                          |
- Other, please give details.....
- **Who were the main patient/client group you worked with as an HCA?**
- |                                 |                                   |  |  |
|---------------------------------|-----------------------------------|--|--|
| Adults <input type="checkbox"/> | Children <input type="checkbox"/> | Learning Disabilities <input type="checkbox"/> | Mental Health <input type="checkbox"/> |
|---------------------------------|-----------------------------------|--|--|
- **How long did you work as an HCA?** .....
- **Which course are you studying?** Diploma ☐ Degree ☐
- **Which branch are you studying?**
- |                                 |                                   |  |  |
|---------------------------------|-----------------------------------|--|--|
| Adults <input type="checkbox"/> | Children <input type="checkbox"/> | Learning Disabilities <input type="checkbox"/> | Mental Health <input type="checkbox"/> |
|---------------------------------|-----------------------------------|--|--|
- **Which year are you studying?** Year One ☐ Year Two ☐ Year Three ☐

## Section B: Becoming a student nurse

### ○ Why do you want to be a registered nurse?

*Rate each of the following in terms of importance:*

	Very important	Important	Not important
Know more about nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be able to do more in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of achievement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gain academic credit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased salary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enhanced status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Career progression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other reasons.....

.....

### ○ How do you feel about being on the programme?

	A great deal	Slightly	Not at all
Apprehensive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optimistic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enthusiastic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhilarated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other .....

.....

If you had an ideal nurse in mind at the beginning of the programme, to what extent have you achieved your ideal?

Not applicable ☐      Not at all ☐      To some extent ☐      To a great extent ☐

## Section C: Your clinical learning experiences as a student

- How does your **former job as an HCA** affect you as a student nurse?

	Never	Sometimes	Always
I find it difficult to adjust to being a student nurse in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to adjust to being a student in the university/academic setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am clear about what is expected of me as a student nurse in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am clear about what is expected of me as a university student	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My former job helps me as a student nurse in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My former job helps me in my academic studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following statements describe situations which nurses encounter.**

- **How confident are you in dealing with:**

	Confident	Slightly confident	Not confident
Difficult patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship difficulties with mentors/supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poorly defined nursing procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi-tasking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The next question is about your clinical skills and how they have changed since the beginning of the programme.**

- **Please indicate your agreement with the following statements:**

	Disagree	Slightly agree	Agree
My range of clinical skills has increased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I now know more about clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have lost some clinical skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can analyse situations in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident I can pass clinical assessments at first attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- **Looking back over your placements (practice experience) during the programme how often did you experience:**



	Never	Sometimes	Always
Mentor/supervisor(s) showed a positive attitude to supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision was based on a relationship of equality and promoted my learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There were sufficient meaningful learning situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was used as an HCA at the expense of my student role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My mentor/supervisor and my clinical teacher/tutor met regularly with me to focus on my learning needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managers had a positive attitude to students and promoted my learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I discussed my work as an HCA with mentors/supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I discussed my work as an HCA with lecturers/tutors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I discussed my work as an HCA with fellow students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following statements reflect aspects of the role of a registered nurse.**

- **How confident are you now that you can:**

	Confident	Slightly confident	Not confident
Act as an advocate for those in your care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support people caring for themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Share information with colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delegate effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the best available evidence to underpin practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deal with complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand the meaning of patient/client consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand professional boundaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep clear and accurate records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrate a commitment to equality and diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uphold the reputation of the profession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Some students continue to carry out paid work as an HCA during the pre-registration programme.**

- **Have you continued to work as an HCA?**
- Yes ☐ **On average how many hours a month?** Hours.....
- No ☐

**What is the impact on you of working as an HCA *during* the pre-registration programme?**

**(If you never work as an HCA go straight to Section D).**

	Never	Sometimes	Always
I find it difficult to adjust to being a student nurse in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to adjust to being a student in the university/academic setting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to be clear about what is expected of me as a student nurse in clinical practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to be clear about what is expected of me as a student nurse in the university/academic setting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My work experience as an HCA helps me as a student nurse in clinical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My work experience as an HCA helps me in my academic studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are your reasons for working as an HCA *during* the programme?

.....

.....

## Section D: Your academic skills

This question is about how confident you are about your academic skills.

○ **How confident are you that you can:**

	Confident	Slightly confident	Not confident
Study effectively on your own in independent/private study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Produce your best work under examination conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respond to questions asked by a lecturer in a full lecture theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your workload to meet deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give presentations to small groups of students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend taught sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attain good grades in your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in profitable debate with your peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask lecturers questions during a lecture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand the materials outlined and discussed with you by lecturers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand course and other teaching materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow the themes and debates in lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare thoroughly for tutorials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read recommended background material	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Produce course work to a required standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Write in an academic style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Confident	Slightly confident	Not confident
Ask for help if you don't understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Make the most of the opportunity of being a university student	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pass assessments at the first attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan appropriate revision schedules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remain adequately motivated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Produce your best work in course assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there anything else you would like to tell us about being a student nurse who used to be employed as an HCA?** (Please note that this section should not be used to make complaints about individual people or practice settings. If you have a complaint please follow your local policy, procedures and guidelines)

- Please use the space overleaf.

**Thank you for completing this questionnaire.**

**If you are willing to take part in a private interview and explain more about your experiences of being a student nurse please provide your contact details below.**

- **Your email address** .....
- **Your telephone number** .....

For more information about this research, please contact:  
Victoria Arrowsmith,  
The Open University,  
Faculty of Health and Social Care,  
Walton Hall,  
Milton Keynes, MK7 6AA.  
Email [victoria.arrowsmith@kcl.ac.uk](mailto:victoria.arrowsmith@kcl.ac.uk)

## APPENDIX 4.2

### LOMBARD UNIVERSITY QUESTIONNAIRE WORD VERSION

## FROM HCA TO REGISTERED NURSE

### i1 - Welcome!

We would be grateful if you would complete the questionnaire which takes about 25 minutes. Throughout the questionnaire the abbreviation 'HCA' is used to cover all assistant nurse roles. There are no right or wrong answers to the questions. It is your views and opinions we are interested in. For further information about this study and what your participation will involve please click [here](#) for our information sheet. Please note your responses will be treated in confidence and that neither you, patient/clients, or colleagues, will be identified in publications that arise from this research. If you wish you can request a summary report of the research to be sent to you. If you have any technical difficulties completing this questionnaire, please email the Survey Team.

*Data Protection Information. The data you provide will be used for research and quality improvement purposes and the raw data will be seen and processed only by The Open University staff and its agents. This project is administered under the OU's general data protection policy guidelines.*

### i2 - Section A: About yourself

#### q1 - What is your gender?

- ☐ Male (M)  
☐ Female (F)

#### q2 - What was your age last birthday?

#### q3 - What was your first language?

#### q4 - What are your qualifications?

*(Tick all that apply)*

- ☐ GCSE (1-3) or equiv. (1)  
☐ NVQ (2)  
☐ A level or equiv. (3)  
☐ First degree (4)  
☐ Post grad. qualification (5)  
☐ Other - please give details: (6) \_\_\_\_\_

#### q5 - What was the main clinical area that you worked in when you were an HCA?

- ☐ (A) Hospital (1)  
☐ Surgical (2)  
☐ Operating Theatres (3)  
☐ Maternity (4)

- ☐ Outpatients (5)
- ☐ Medical (6)
- ☐ (B) Community (7)
- ☐ Nursing Home (8)
- ☐ GP Practice (9)
- ☐ Rehabilitation (10)
- ☐ Residential Home (11)

☐ Other - please give details: (12)\_\_\_\_\_

**q6 - Who were the main patient/client groups you worked with as an HCA?**

- ☐ Adults (1)
- ☐ Children (2)
- ☐ Learning Disabilities (3)
- ☐ Mental Health (4)

**q7 - How long did you work as an HCA?**

**q8 - Which branch are you studying?**

- ☐ Adults (1)
- ☐ Mental Health (2)

**q9 - Which practice course are you studying?**

- ☐ KYN107 (1)
- ☐ KYN291 (2)
- ☐ KYN292 (3)

**i3 - Section B: Becoming a student nurse**

**q10a - Why do you want to be a registered nurse?**

*(Please rate each of the following in terms of importance)*

	Very important (1)	Important (2)	Not important (3)
Know more about nursing (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Be able to do more in clinical practice (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sense of achievement (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gain academic credit (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased salary (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enhanced status (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Career progression (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q10b - Other reasons:**

**q11a - How do you feel about being on the programme?**

	A great deal (1)	Slightly (2)	Not at all (3)
Apprehensive (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxious (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stressed (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fearful (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overwhelmed (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optimistic (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motivated (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enthusiastic (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exhilarated (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q11b - Other:****q12 - If you had an ideal nurse in mind at the beginning of the programme, to what extent have you achieved your ideal?**

- ☐ Not applicable (1)  
☐ Not at all (2)  
☐ To some extent (3)  
☐ To a great extent (4)

**i4 - Section C: Your clinical learning experiences as a student****q13 - How does your former job as an HCA affect you as a student nurse?**

	Never (1)	Sometimes (2)	Always (3)
I find it difficult to adjust to being a student nurse in clinical practice (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it difficult to adjust to being a student in the university/academic setting (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am clear about what is expected of me as a student nurse in clinical practice (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am clear about what is expected of me as a university student (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My former job helps me as a student nurse in clinical practice (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My former job helps me in my academic studies (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q14 - The following statements describe situations which nurses encounter. How confident are you in dealing with:**

	Confident (1)	Slightly confident (2)	Not confident (3)
Difficult patients (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship difficulties with mentors/supervisors (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	Confident (1)	Slightly confident (2)	Not confident (3)
Poorly defined nursing procedures (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult relatives (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult decisions (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical tiredness (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multi-tasking (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult colleagues (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q15 - The next question is about your clinical skills and how they have changed since the beginning of the programme.**

*(Please indicate your agreement with the following statements)*

	Disagree (1)	Slightly agree (2)	Agree (3)
My range of clinical skills has increased (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I now know more about clinical practice (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have lost some clinical skills (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I can analyse situations in clinical practice (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident I can pass clinical assessments at first attempt (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q16 - Looking back over your placements (practice experience) during the programme how often did you experience:**

	Never (1)	Sometimes (2)	Always (3)
Mentor/supervisor(s) showed a positive attitude to supervision (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supervision was based on a relationship of equality and promoted my learning (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There were sufficient meaningful learning situations (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was used as an HCA at the expense of my student role (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My mentor/supervisor and my clinical teacher/tutor met regularly with me to focus on my learning needs (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managers had a positive attitude to students and promoted my learning (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I discussed my work as an HCA with mentors/supervisors (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I discussed my work as an HCA with lecturers/tutors (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I discussed my work as an HCA with fellow students (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q17 - The following statements reflect aspects of the role of a registered nurse. How confident are you now that you can:**

	Confident (1)	Slightly confident (2)	Not confident (3)
Act as an advocate for those in your care (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support people caring for themselves (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Share information with colleagues (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delegate effectively (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Manage risk (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Use the best available evidence to underpin practice (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deal with complaints (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand the meaning of patient/client consent (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand professional boundaries (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep clear and accurate records (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrate a commitment to equality and diversity (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uphold the reputation of the profession (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q18 - Some students continue to carry out paid work as an HCA during the pre-registration programme. Have you continued to work as an HCA?**

- ☐ Yes (1)  
☐ No (2)

CONDITION	f('q18')== '1'	
	true Question ()	false

**i5 - Section C: Your clinical learning experiences as a student**

**q19 - On average, how many hours a month did you continue to work as an HCA?**

**q20 - What is the impact on you of working as an HCA during the pre-registration programme?**

	Never (1)	Sometimes (2)	Always (3)
I find it difficult to adjust to being a student nurse in clinical practice (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it difficult to adjust to being a student in the university/academic setting (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it difficult to be clear about what is expected of me as a student nurse in clinical practice (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I find it difficult to be clear about what is expected of me as a student nurse in the university/academic setting (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My work experience as an HCA helps me as a student nurse in clinical practice (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My work experience as an HCA helps me in my academic studies (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q21 - What are your reasons for working as an HCA during the programme?**

END

Condition f('q18')== '1'

**i6 - Section D: Your academic skills**

**q22 - This question is about how confident you are about your academic skills. How confident are you that you can:**

	Confident (1)	Slightly confident (2)	Not confident (3)
Study effectively on your own in independent/private study (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Produce your best work under examination conditions (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respond to questions asked by a lecturer in a full lecture theatre (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Manage your workload to meet deadlines (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Give presentations to small groups of students (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attend taught sessions (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attain good grades in your work (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engage in profitable debate with your peers (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ask lecturers questions during a lecture (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand the materials outlined and discussed with you by lecturers (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand course and other teaching materials (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follow the themes and debates in lectures (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prepare thoroughly for tutorials (13)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Read recommended background material (14)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Produce course work to a required standard (15)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Write in an academic style (16)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ask for help if you don't understand (17)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make the most of the opportunity of being a university student (18)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pass assessments at the first attempt (19)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plan appropriate revision schedules (20)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remain adequately motivated (21)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Produce your best work in course assignments (22)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**q23 - Is there anything else you would like to tell us about being a student nurse who used to be employed as an HCA?**

*(Please note that this section should not be used to make complaints about individual people or practice settings. If you have a complaint please follow your local policy, procedures and guidelines)*

i7 - Thank you for completing this questionnaire.

q24 - If you are willing to take part in a private interview and explain more about your experiences of being a student nurse please provide your contact details below.

Your email address: (1) \_\_\_\_\_

Your telephone number: (2) \_\_\_\_\_

STOP

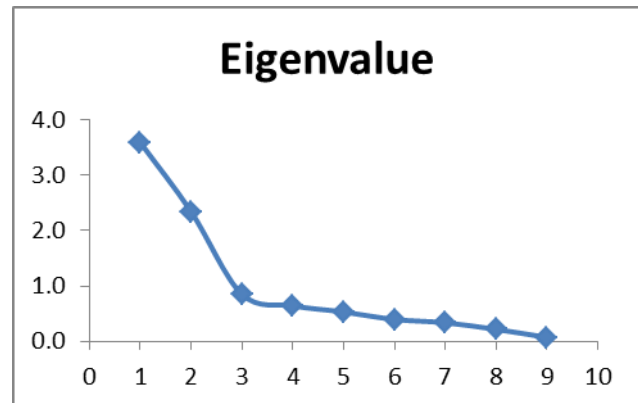
**Complete** – Your responses have now been recorded.

*For more information about this research, please contact: Victoria Arrowsmith, The Open University, Faculty of Health and Social Care, Walton Hall, Milton Keynes, MK7 6AA. Email: victoria.arrowsmith@kcl.ac.uk You will now be directed to StudentHome.*

## APPENDIX 4.3

### MPLUS EFA RESULTS 141015

Number	Eigenvalue
1	3.59
2	2.34
3	0.85
4	0.64
5	0.53
6	0.40
7	0.34
8	0.22
9	0.07



#### Promax factor loadings

item	F1	F2	F2	
1	0.91	-0.11	-0.13	Apprehensive
2	0.79	-0.07	0.10	Anxious
3	0.15	0.07	0.92	Stressed
4	0.69	0.06	0.07	Fearful
5	0.53	0.06	0.16	Overwhelmed
6	-0.20	-0.57	0.24	Optimistic
7	0.06	-0.96	-0.06	Motivated
8	0.07	-0.98	-0.05	Enthusiastic
9	0.02	-0.67	-0.02	Exhilarated

#### Promax factor correlations

	F1	F2	F3
F1	1.00		
F2	0.26	1.00	
F3	0.41	0.09	1.00

## **APPENDIX 4.4**

### **INTERVIEW TOPIC GUIDE**

#### **From HCA to Registered Nurse: exploring the transitions of pre-registration student nurses**

##### **Preamble**

I am interested in the journey from HCA to student nurse and beyond. This conversation is an exploration of changes you have experienced since you began the programme. I'm interested in your thoughts about the journey, your feelings or emotions, and how these have changed over time. I'm interested in how you explain any changes you've experienced during the journey so far and what you do and have done to help yourself through the journey.

During our conversation I'd like to start by asking you a little about yourself and why you wanted to become a registered nurse. Then I'd like to find out about your perceptions of yourself (your views about yourself) and how these might have changed since you began the programme. I'd also like to find out about your emotional journey as a student nurse and what you've done to cope with being a student, to ease your journey. I'd like to know what and who have helped you, what and who haven't helped (no names please!). Then finally, perhaps, sum up your experience so far.

##### **TOPIC ONE**

###### **About you**

I'd like to know a little bit about your previous work as an HCA and what made you want to become a registered nurse.

List of placements and modules undertaken

[short recap/seek affirmation of understanding/probe further if need to]

##### **TOPIC TWO**

###### **Perceptions about self**

I'd like to know what thoughts went through your mind the first day in clinical practice; and in the classroom.

Perception/views/thoughts about yourself: have they changed since the start? How have they changed? What made them change?

Views on others (prompts: peers, workplace mentors, clinical colleagues, lecturers, and other university staff) changed? How have they changed? What made them change?

[short recap/seek affirmation of understanding/probe further if need to]

### **TOPIC THREE**

#### **Feelings about self**

I'd like to know how you felt the first day in clinical practice: and in the classroom.

How do you feel now about going into a new CP area? Coming back to uni? Have your feelings (about both) changed? How have they changed (examples)? What has made them change?

### **TOPIC FOUR**

#### **Coping**

What did you do to cope with your feelings about practice and classroom work at the start? What do you do now in practice: in uni (examples)? What made you change/add to (develop) your strategy?

[short recap/seek affirmation of understanding/probe further if need to]

### **TOPIC FIVE**

#### **Resources**

Which placements have you been to? Which did you like best? Why? Which did you like least? Why? Examples.

What do you do to improve your practice?

What modules have you taken at uni? Which did you like best? Why? Which least? Why? What do you do to improve your performance?

Who most helps your learning? Examples of what's helpful behaviour and what is not. What else helps? (examples). What doesn't help? (examples). Have your views changed on what helps you? Changed views on what doesn't help? What's made you change your views? Examples?

### **TOPIC SIX**

#### **Perceived roles**

What did you think was the difference between the role of HCA and that of student at the start of the programme? Has your view changed? How? What's the reason for the change?

What do you do now that's different to when you started in practice; and uni.

What did you think registered nurses did when you started? Has your view changed? How?

[short recap/seek affirmation of understanding/probe further if need to]



## **TOPIC SEVEN**

### **Summary of change**

Summarise how things (thoughts, feelings and actions) have changed since the start (practice and uni).

Feelings about becoming a registrant; have they changed since the start? How?

What do you plan to do as a registrant? Have your views changed since the start?

Is there anything else you wish to say or think I should know?

[short recap/seek affirmation of understanding/probe further if need to]

**APPENDIX 4.5**  
**PERSONALISED REMINDER 1**



**From Health Care Assistant to Registered Nurse**

Dear ^forename^,

I recently sent you an email inviting you to take part in a research study of student nurses formerly employed as HCA/assistant nurses. This research involves students from two universities and is being conducted by me as a PhD student at Kings College London.

As a student nurse at the end of the Common Foundation Programme your views are essential in helping me to understand what helps and what hinders learning for students like you. The findings of the research will lead to recommendations to improve learning in clinical practice as well as at the university. The information sheet gives full details of this study and the important part you can play in it. <link to the info sheet>.

The confidence that can be placed in the findings depends on as many people taking part as possible and so your individual participation is very important. The online questionnaire remains open until February 13<sup>th</sup> which I hope will allow you enough time to participate. Your contribution will be very much appreciated.

Once you have completed and returned your questionnaire, if you would like a summary report of the research do please let me know and I will send you a copy. Please send your request to my email address below.

The questionnaire should take about 25 minutes to complete. **There are no right or wrong answers** to the questions and all your responses will be treated in confidence.

If you have any technical difficulties completing the questionnaire please do email the Survey Team who will be pleased to help you.

I look forward to hearing from you

Best wishes

Victoria Arrowsmith

Postgraduate research student, Kings College London.

victoria.arrowsmith@kcl.ac.uk

**APPENDIX 4.6**  
**PERSONALISED REMINDER 2**



**From Health Care Assistant to Registered Nurse**

Dear ^forename^,

We recently sent you an email inviting you to take part in a research study of student nurses formerly employed as HCA/assistant nurses. As an expert your views, experiences and opinions will be very much appreciated and will form a vital part of the research. The findings of the research will lead to recommendations which will improve learning in clinical practice as well as at the university, for students like you. The information sheet gives full details of this study and the part you can play in it. <link to the info sheet>.

The confidence that can be placed in the findings depends on as many people taking part as possible and so your individual participation is very important. The online questionnaire will remain open for,<insert one or two> additional week<s>, until <insert the date > which I hope will allow you enough time to participate.

Through participating in this research study you will have direct experience of being a research participant. Once you have completed and returned your questionnaire, if you send me your email address, I will mail to you a letter for your portfolio. The letter will be sent from Kings College London and will certify your involvement in this study. Please send your request to my email address below. In addition, if you would like a summary report of the research do please let us know and I will send you a copy.

We anticipate the questionnaire should take about 25 minutes to complete.

**There are no right or wrong answers** to the questions and all your responses will be treated in confidence.

If you have any technical difficulties completing the questionnaire do please feel free to email the Survey Team who will be pleased to help you.

We hope very much that you will be able to take part and look forward to hearing from you

Best wishes

Victoria Arrowsmith

Post graduate Research Student, Kings College London.

[victoria.arrowsmith@kcl.ac.uk](mailto:victoria.arrowsmith@kcl.ac.uk)

## APPENDIX 4.7

### FLYER REMINDER CASTLETON UNIVERSITY

# **FROM ASSISTANT TO REGISTERED NURSE: THE EXPERIENCES OF STUDENT NURSES. RESEARCH UPDATE.**

The first part of the research took place at the beginning of your academic year when the survey of student nurses with past Healthcare Assistant/assistant nurse experience began. Many thanks to all of you who completed the questionnaire. Your responses were very interesting and helped me to develop the next part of the research: the interviews. Some of your group have now taken part in follow up interviews and I would like to extend my thanks to you as well.

The next stage of the research involves the second part of the survey and I will be asking you to fill out a questionnaire at the end of your academic year. Following on from this I hope some of you will be willing to take part in further interviews. In the meantime if you would like to suggest topics for including in this final phase of data collection please email me:

[Victoria.Arrowsmith@kcl.ac.uk](mailto:Victoria.Arrowsmith@kcl.ac.uk)

I'm looking forward to being in touch with you again and thank you for supporting this research.

*Victoria*

Victoria Arrowsmith,  
Post graduate research student,  
Kings College London.

## APPENDIX 4.8

### LETTER OF PARTICIPATION



**Florence Nightingale  
School of Nursing  
And Midwifery**

James Clerk Maxwell Building  
King's College London  
57 Waterloo Road  
London  
SE1 8WA  
Telephone: 020 7848 4698  
Fax 020 7848 3555

March 2011

Dear Student Nurse <name>

From Health Care Assistant to Registered Nurse: exploring the transitions of pre-registration student nurses.

I write to confirm and thank you for participating in an interview for the above study. This study aims to understand the experiences of student nurses who have worked as an assistant nurse or Health Care Assistant for a minimum of six months before becoming a pre-registration student nurse. It explores, in particular, the factors that enable and constrain role transition from assistant nurse to registered nurse. The study collects data from first, second and final year students, and part-time equivalent students, from two universities in the UK; you were one of these students. It is a postgraduate research project and forms part of one of the research programmes based in the School of Nursing and Midwifery at Kings College London.

I do hope that you will be willing to continue to support the project. You took part in an interview in the middle of the academic year one and in so doing provided information which is valuable and much appreciated. The next phase of the study involves a second questionnaire survey at the end of the current academic year and I will be in contact with you again then.

Thank you once again for supporting this important study.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'V. A. Arrowsmith'.

Victoria Arrowsmith  
Post graduate research student,  
Kings College London.

## **APPENDIX 4.9**

### **PNM RESC FULL APPROVAL**

Victoria Anne Arrowsmith  
237 Aylesbury Road  
Bierton  
Buckinghamshire  
HP22 5DS

02 August 2010

Dear Victoria Anne

**PNM/09/10-138 From health care assistant to registered nurse: Exploring the transitions of pre-registration student nurses**

Thank you for sending in the amendments requested to the above project. I am pleased to inform you that these meet the requirements of the PNM RESC and therefore that full approval is now granted.

Please ensure that you follow all relevant guidance as laid out in the King's College London Guidelines on Good Practice in Academic Research  
([http://www.kcl.ac.uk/college/policyzone/attachments/good\\_practice\\_May\\_08\\_FINAL.pdf](http://www.kcl.ac.uk/college/policyzone/attachments/good_practice_May_08_FINAL.pdf)).

For your information ethical approval is granted until **02 August 2013**. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed). You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

If you do not start the project within three months of this letter please contact the Research Ethics Office. Should you need to modify the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications:  
<http://www.kcl.ac.uk/research/ethics/applicants/modifications.html>

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chairman of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (<http://www.kcl.ac.uk/research/ethics/contacts.html>). We wish you every success with this work.

With best wishes

Yours sincerely

Jim Summers  
Senior Research Ethics Officer

c.c. Mrs Sarah Robinson



## APPENDIX 4.10

### ETHICAL APPROVAL CASTLETON UNIVERSITY

**From:** Gurch Randhawa [Gurch.Randhawa@beds.ac.uk]

**Sent:** 28 July 2010 08:47

**To:** V.A.Arrowsmith

**Subject:** Re: Research with The [REDACTED] & KCL

Dear Victoria

I have now received the documentation for the study. It's a really interesting piece of work. I've approved the study.

All the best

Gurch

P.S. Please pass on my regards to [REDACTED] when you next see him.

Gurch Randhawa PhD, FFPH  
Professor of Diversity in Public Health  
Director, Institute for Health Research  
University of Bedfordshire  
Putteridge Bury  
Hitchin Road  
Luton  
Bedfordshire  
LU2 8LE  
Tel: 01582 743797 or 07718 517196  
Fax: 01582 743918  
email: gurch.randhawa@beds.ac.uk  
www.beds.ac.uk/ihr

>>> "V.A.Arrowsmith" <v.a.arrowsmith@open.ac.uk> 25/07/2010 09:51 >>>

Hello Gurch

I think you have by now received the documents requesting ethical approval to undertake the study "From Health Care Assistant to Registered Nurse: exploring the transitions of pre-registration student nurses." I would like to provide an update on the information in the submission I made. Kings have granted provisional approval for the study subject to some minor amendments and further information. Kings have requested evidence of written approval from [REDACTED] University and the University of [REDACTED] because I indicated on the Kings application that I would approach both institutions for ethical approval. The [REDACTED] University have indicated that I do not need ethical approval from The [REDACTED] because I am a student at Kings and it is the responsibility of Kings to grant approval. The [REDACTED] only require that I follow due process with respect of accessing students.

Thank you for considering my application. Please don't hesitate to contact me if you require more information.

Best wishes

Victoria

Victoria Arrowsmith

## APPENDIX 4.11

### ETHICAL APPROVAL LOMBARD UNIVERSITY

**From:** J.M.Oates  
**Sent:** 08 July 2010 17:57  
**To:** V.A.Arrowsmith  
**Subject:** RE: Proforma  
Dear Victoria Arrowsmith,

My first comment is that you will need the approval of the [REDACTED] Student Research Project Panel in order to carry out research with OU students.

<http://iet-intranet.open.ac.uk/research/index.cfm?id=7082>

My second point is to note that if you are registered for your doctoral programme with King's College, as it appears from the proforma, it should be the King's REC that you apply to, not the [REDACTED]s.

I have looked through your proforma and to me the ethics protocol looks well thought through. King's uses a similar application form, so you will not have a great deal of work to do if you need to apply there.

Please let me know the position.

John Oates  
Chair, HPMEC

**From:** IET-SRPP  
**Sent:** 16 July 2010 11:11  
**To:** V.A.Arrowsmith  
**Cc:** 'sarah.robinson@kcl.ac.uk'

**Attachments:** SRPP 2010\_087 Handling Concerns About Practice.doc

Dear Victoria

With reference to your recent Student Research Project Panel application 'Health and Social Care', I am pleased to report that Panel **approval** has been **given**. The Panel do have some recommendations that they would like you to consider please:

- **Invitation –**
  - We suggest in your initial letter to students that you take the opportunity to introduce the study as a whole and the level of involvement that will be required from students who volunteer to take part. You should also explain that it is part of a wider study with other Universities (name them) and how the findings will be of benefit to future studies. You could adapt and expand some of the wording in Section 5b of your application.
  - Time estimates - given the amount of contact planned it is important to be clear what is involved such as an estimate of the time needed to take part – especially for the interview. Please bear in mind that students working in this area may have quite full schedules fitting around shift work patterns etc.

- Please add a note to the effect that confidentiality will be maintained (the End of Course Survey is a good example of what students are told about research). See note about Dataset below.
- It is important to be clear what approach you are taking to this research – if the research being carried out by you purely as a student (this needs to be explained) or is it is mixed approach (i.e. work and study related)? You will need to clearly identify who are you and your approach.
- Additional contact name - there needs to be an additional contact on the invitation so that anyone who has any concerns can contact a member of [REDACTED] staff. This is standard practice for any research undertaken by PhD students.
- Students who want to raise concerns about practice..... [REDACTED]  
[REDACTED] make it clear the study is not the place to raise any concerns about practice and how these are addressed. I enclose an example letter with the relevant text highlighted.
- Questionnaire. In your letter, you mention two questionnaires – one at the beginning and end of each module you have specified. Which questionnaire did you submit with your application?

Please could we have sight of the other questionnaire.

- **Dataset** – Have you made any arrangements to be supplied with datasets by the IET Survey Office for your research? As outlined by [REDACTED], if you are going to use personalised rather than anonymised datasets for your research, this is permissible as long as you inform the student nurses when you initially approach them about taking part in the research.
- **Consent Form** – provided the advice given by [REDACTED] with regard to data protection is followed the Panel are happy for you to use Kings' paperwork.

We always inform applicants that Panel approval does not imply either ethical or sample approval should either of these be required. As you know [REDACTED] is the person to liaise with in respect of your sample, [REDACTED] is on leave this week but will be in touch with regard to your sample shortly.

Please don't hesitate to get back in touch if you would like further information or explanation with regard to the recommendations.

With best wishes

Jane

Jane Baines

Student Research Project Panel Coordinator

## APPENDIX 4.12

### INFORMATION SHEET FOR PARTICIPANTS

#### INFORMATION SHEET FOR PARTICIPANTS

REC Reference Number PNM/-0/10-138



#### YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

#### **From Health Care Assistant to Registered Nurse: exploring the transitions of pre-registration student nurses**

I would like to invite you to participate in this postgraduate research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information.

- This research aims to understand the transitions that student's experience who have worked as an assistant nurse or Health Care Assistant (HCA) for at least six months before becoming a pre-registration student nurse. It aims to explore the impact of your previous work on your present clinical practice experiences, as well as your academic learning experiences. It will explore the factors that enable and constrain the transition that students like you experience as you move from being an assistant nurse/HCA to becoming a Registered Nurse. The study involves first, second and final year students from two universities and forms part of the stream of research at Kings College London.
- You will be requested to fill out a questionnaire at the beginning and end of the year and following analysis of the questionnaire I would like to interview a small number of students. The questionnaire and interviews will provide you with an opportunity to give your views about what is needed to support students like you through the pre-registration nursing programme. The questionnaire also provides you with an opportunity to reflect on your academic experiences and clinical practice. You will be contributing to the improvement of knowledge about HCA/assistant nurses who become pre-registration nursing students, which at present is very limited. A greater understanding of students like you has the potential to contribute not only to your present experience, but also to the experiences of nursing students in the future. It will benefit policy makers in clinical practice and university curriculum developers when planning institutional as well as individual teaching and learning experiences. It will also be of practical use to mentors in clinical practice when they plan and evaluate learning experiences for students like you. Better understanding might also impact on the "drop out" rates of students with prior HCA/assistant nurse experience.
- You have been approached to take part in this research because your prior experience as an HCA/assistant nurse makes you an expert on the influences that affect you as you learn to be a Registered Nurse. Students with a minimum of six months experience of being an HCA/assistant nurse prior to starting a pre-registration nursing programme are invited to take part in this research.

- The study involves the common foundation programme, second and final year students filling out a questionnaire at the beginning and end of the year. After completing the questionnaire I would like interview a small number of you mid year and at the end of year, to find out in more detail about your experiences and opinions.
- Before completing the questionnaire you will be given this information sheet to keep. If you are selected and agree to be interviewed you will be offered this information sheet again, and in addition you will be asked to sign a consent form.
- Students studying in a traditional manner that requires regular attendance at the university will be requested to complete the questionnaire on the university premises and hand it in there. Students studying at distance will be sent the questionnaire by email and asked to submit it electronically by pressing the "finish" button at the end of the questionnaire. The questions posed in the survey are identical for both Universities. At the end of the questionnaire you can indicate if you are willing to be contacted by the researcher to discuss the possibility of taking part in an interview. Consent for the questionnaire is given once it is submitted by you.
- Following the return of each questionnaire and analysis of its findings, I would like to invite some of you for an interview. You will be given this information sheet again to read and keep, and you will be asked to sign a consent form. The time and place of the interview will be arranged to suit you. Students will be invited on the basis of responses given in the questionnaire. If you are a student studying in a traditional manner and attend the university premises on a regular basis, you will be interviewed face to face and privately at the university. Students studying through distance learning will be interviewed via the telephone, because you are geographically widely spread out across the UK. All interviews will take the form of an informal conversation and take between half and one hour. I would like to talk to you about your opinions and experiences of being a student nurse. I am interested in your ideas about what helps you and what impedes your journey towards registration.
- I will also send a reminder to all students in the middle of the year about the end of year survey and ask if there is anything you are currently experiencing that you think could be usefully discussed during the end of year interviews.
- You will be only be asked to complete the questionnaires and take part in interviews at times that do not interfere with your assessments. In particular, at the end of the final year the questionnaire and interviews will take place after you have completed the pre-registration programme but before you become registered with the Nursing and Midwifery Council. This is so that this research does not interfere with your final assessments.
- I will ask your permission to contact each of you after the interview if I need to clarify the ideas that we discussed. This can be done face to face or by telephone.
- The risk involved in taking part in this study is very low. There is a very small risk that you might find the interview stressful or emotionally upsetting. I will routinely provide information concerning occupational health/student support services. You should also note that this research sits entirely outside of all university programme requirements and is not linked in any way to assessments. Although I am employed as a lecturer in nursing

at The Open University I am obliged by the law and by ethical guidelines to hold any information given by you in strict confidence. You may also be interested to know that Kings College London provides no fault compensation for those involved in research.

- I will follow ethical and legal practice, including the Data Protection Act (1998). All information collected during the course of this research will be handled in strict confidence. If you take part in the survey consent to do so is assumed once you complete the questions and hand them to the researcher (or nominated other) or when you press the finish button on the electronic version of the same survey. All interviews will be digitally recorded and transcribed and recordings deleted once transcription has taken place. The information obtained from you from both questionnaires and interviews will be stored securely on a university server or in the case of hard copies in a locked drawer with only the researcher holding the keys. Electronic data will be password protected all the data collected will be used only for the purposes of this study. The only person who will have direct access to the data is me. The recording of your interview will not be heard by anyone except me or a person specially selected to transcribe the data into text. When words are written down from the interviews, or information taken from the survey, your identity and any references that might identify you personally will be removed. All the information you give will be made anonymous so that it will not be possible to identify you, clinical settings, patients, clients, or colleagues, from the information that you have given. In addition, all the information that I share with my PhD supervisors will be made anonymous.
- You are free to withdraw from this study at any time and do not need to give a reason. Any data collected before you make this decision will be destroyed.
- At the end of the study all information and data connected during the course of the study will be stored securely on a university password protected server, or hard copies stored in a locked filing cabinet, then destroyed after 7 years.
- I am a Registered Nurse and as you would expect, the only exception to maintaining strict confidentiality would be when clear breaches of the Nursing and Midwifery Council "The Code" (2008) are apparent and patients, or clients, or colleagues, are placed at risk. In this instance I will follow local and national guidelines relating to issues that arise.
- As discussed above the interviews will provide you with an opportunity of discuss your views about supporting students, reflecting on your practice, contributing to the knowledge base about students such as yourself, and helping policy makers, mentors and lecturers in the future. I am unable to offer you payment for taking part in this research, but I will travel to your location if you are asked to take part in face to face interviews. If requested to take part in telephone interviews I will ring you. In each situation you should not incur any expenses. As a thank you, you will receive a summary report of the research and in addition, if requested, I will give presentations of summary findings to you as participants, employing organisations and, or, the university where you are studying. In addition, the outcomes of this study will be written up as a PhD thesis and findings disseminated through peer reviewed journals and conference presentations.

- Name and contact details of the researcher:

Victoria Arrowsmith  
Senior Lecturer Nursing  
The Faculty of Health and Social Care  
Walton Hall  
Milton Keynes MK& 6AA  
Email: [v.a.arrowsmith@open.ac.uk](mailto:v.a.arrowsmith@open.ac.uk)  
Telephone: 01908 274066

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Dr Sarah Robinson  
James Clerk Maxwell Building  
37 Waterloo Road  
London, SE1 8WA  
Email: [sarah.robinson@kcl.ac.uk](mailto:sarah.robinson@kcl.ac.uk)  
Telephone 020 7848 4698

## APPENDIX 4.13

### INTERVIEW TRANSCRIPT MARKED UP

TI YI  
LOM  
107

Interview Transcript OUA1\_17[14]

Name: Jean  
Identifier: OUA1\_17[14]  
Date: 06.04.11  
Venue: Telephone  
Selection score: 14  
Survey number: OUA1\_17[14]  
Interview transcription number: C0101

mean to explain

J I've been thinking about this for a couple of days and I think you have explained the reasons for doing it quite well

I So what I will do is ask you what you..... And start off and ask you a little bit about your previous HCA experience. What did you do? How long were you an HCA?

J Right well I began by doing my nursery nursing before that and I became a nursery nurse and used to work for an agency at schools. But I wanted to be a nursery nurse in hospitals so there was hardly any nursery nurse jobs in the hospital so I decided to become an HCA to get some hospital experience so if any jobs was to become vacant I would be able to apply for them and probably get the job better with hospital knowledge. So I applied for agency work at X hospital and I did a two day course with them and then was given shifts straight onto hospital wards and so on. I did that for a year and then actually I did enjoy being an HCA very hands on I just enjoyed the range of different places that I was going to. One of the places I enjoyed most was the women's services that I work in now. It's children's and women's services and mainly gynaecology and obstetrics and a vacancy became available there on the clinic on the wards. So I applied for the job which I had done quite a lot of bank shift in and got the job and have been there ever since.

I And how long have you held that job?

J Its 30 hours a week and I've been there 11 years now and I've really, really enjoyed it and the reason being we was at X hospital and moved to Y hospital and then X and Y merged and the womens services was brought over to X hospital so we all kind of came together and which was really interesting because when we had more clinics and more variety of gynaecology and IVF and fertility control which was terminating pregnancies which was one end to the other so I saw the smaller specialised areas like endocrine menopause rather than just general gynae. So it was a very big umbrella and very interesting. So now I'm a senior HCA done my NVQ 3 and 4 while I have been there and I have kind of done all of the clinics and do more or less a similar job as the nurses. The only thing I don't give is medication.

service  
moving

Key only  
def ult

I So you sort of fell into the roll almost and you found you really enjoyed doing it. But what made you decide to become a registered nurse?



J Well I had wanted to do nursing for a while. I felt like I wanted to progress and I had got to the top of as far as I could go with this particular area and even when I had looked in other areas and carried on working on the bank thinking well maybe it might be a progression somewhere else. But I still came back to women's services which I did enjoy and so I decided to do my NVQ 3 because that at that particular time there was a framework that had come out that said if you get onto NVQs and get your levels you can then kind work your way up to a higher grade which obviously would be financially benefit but also I could go and do other things. So I did my NVQ level 3 and spoke to a member of staff about it and she said there would be higher levels coming in so decided to take my NVQ 3 then to be told that there was a freeze on vacancies and actually we was a lot of debt in the NHS and there wouldn't be any progression there. But the really good thing, so I took my NVQ level 3 which I really enjoyed and that kind of opened the flood gates for knowledge again and to actually go into education. I then took my maths and English as well it was all within the Trust and all for free which I took advantage of and it just kind of helped me because now I've that was my entry into my nursing. I was trying before in the normal routes but I got stuck because of financial reasons and the bursary was so low but I thought I would be able to cope but I didn't and that it wasn't going to work and carried on being an HCA. But also as well as doing my NVQs and maths and English I was out for putting other little feathers in my cap and gone on training courses and anything free and courses that was available for me to go which I did and I went on many courses. And then a few years ago I approached my, my line manager and approached her twice to go on this course through the UofDL which she refused because we the staff was too short, we didn't have enough staff and she refused to support me on my application. So I left it for another year and asked her again and she said we are still short staffed and then she retired. Then our line manager, our new line manager came along and she pulled me out and said J you are so good at your job, so good at helping the staff the junior doctors and the new staff coming through why haven't you ever done your nursing? So I mentioned what had happened in the past and she said why don't you apply again and that is how it happened. So then I applied and got an interview and got a place supported obviously by my line manager and my matron, which I am thoroughly enjoying.

know more

academic confidence boosted

I good! So when you were an HCA what sort of jobs did you do? Was it all out patient work?

J We sort of rotated onto the ward as well. I kind of didn't mind going onto wards because I already did bank on wards so it is kind of a different job altogether outpatients. But outpatients in my job is more clinical and technical, machinery to use like in colposcopy and lots of machines to use whereas on the wards its most hands on. Even though in outpatients it can be, observations bed making, laundry a small amount of medication and so on. But its kind of two different roles but all within a HC. Within the clinic my role was to prepare clinics. I won't go through the whole list because we'll be here all night and actually checking in the system and training medical staff and because of the different clinic's and the different areas that was merged together our role then became more interesting because I could learn on the ward as well. I can honestly say that after 11 years of being there I have never got bored. Every day is different and there is always something new and I have been kind of lucky that all the doctors and consultants that I work with are very good at training and teaching. It's a teaching hospital so we have got medical students there

medical (nurses) train

all the time they are every good at training so anything that I want to find out, so I have been blessed with teaching

I J from time to time I will summarise what I think you are saying but please tell me if I haven't got it right. So basically what you are saying to me is that you spent 11 years as an HCA over a whole range of roles some of it basic, fundamental care on wards and some more technical stuff on OPD and really you harboured this desire to do your nurse training and the opportunity arose

HCA role  
no more  
progression

J yes and I just couldn't progress more as a HC and also I was wanting to do that for a while but not being able to do it because of the financial aspects

I What sort of things did you want to progress to do

medications  
+  
accountability  
responsibility  
knowledge

J Well I think it was mainly the medications side of things because as a Health Care you can kind of give paracetamol and eye drops which we don't give in our clinic but that kind of minimal medications. I wanted to go on the IV drips and giving medication injections and so on so I was interested in that. Also there was the accountability. Even though you are accountable as an HC and as a human being really I felt that I wanted to take more responsibility. I was kind of interested in the ethics and found myself wanting to know underpinning knowledge and instead of just going in and doing my job, asking myself questions of why we was doing it that way because of the doctors and nurses because I was just finding myself wanting to go further and further into why we actually do this and that is when I realised that I really wanted to do this nursing because if not you are going to become bored and frustrated you know. You know HC have been there 50 years and knows everything that's happening but never progressed. So yea for me it as underpinning knowledge and kind of wanting to progress further as a qualified nurse. Not kind of wanting to come in and do my job and go home.

I And now that you are a student nurse has your view of what a registered nurse does changed?

J Yes. Yes definitely. Now, well I always kind of looked at nurses and respected nurses because I know they do the 3 years in the university whatever their age and whatever they do. I've always respected and I know its wrong to say this but I do think the NHS is an hierarchic people from the old school where you still respect the people above. Not to the extent where we are down trodden far from it and we are all a team but I do kind of like to give respect to the consultants and the higher qualified nurses and everybody really. But now I look at nurses in a different way. Before when I was a health care I came and did my job and I could leave all the responsibility and if anything wasn't right I could hand that over to a nurse and nine times out of ten they would quite happily take it from me. If I felt out of my depth you know if I said I don't feel comfortable doing this or I'm not quite sure about this lady but don't know why they used to kind of take over. And now that I am a student nurse I have now been let into this kind of private club and I can now kind of understand what its all about really. And probably respect them more than I have done before because I have realised its not about doing the job and going home its taking it that mile extra, you know that bit more than the norm really. And that I don't mean that, I don't mean as in a job really as in a personal thing really. You don't finish at 5

PRIVATE  
CLUB  
  
respect

or 7 or whatever shift you are on as a nurse you carry on until you are comfortable. I have seen nurses come in on their day off to tend to patients and in their own time to see that they are OK. And they say that nursing is a vocation and that's true. I don't think it's a job its for life and it goes beyond the ward really

I So I suppose what you are really saying to me is you could see the range of jobs tasks that registered nurses did, it attracted you to do that but you hadn't fully appreciated what it means to be accountable and what it means to be responsible?

J That's right yeas

I I like your phrase "let into the private club!" So can I take you back a little while. You are in your first year and you are quite a way in now

J Yea 7 months now and ready to take on have my exams in June so revising at the moment and my Health and Social Care exam and I'm doing another module at the side of that so yea

I So can you think back to your first day in your home base area that you had been working in as an HCA. What did it feel like as a student nurse?

J Well when I first went in because obviously we change uniform and we have a green tunic and as a student nurse you have a white tunic so straight away you are different. I was a bit nervous but I spoke to my line manager before coming in as a student and he was making humour of it really. When I came in for the first time my line manager says you are the tea maker you have to make coffee and tea for everybody because you are a new student. So I was nervous because I felt that a few elderly nurses that was ready for retirement and I felt a bit uncomfortable about how they would feel about it uumm these ten sessions that we was actually going in as a student the transitional role and it was placed there for a reason so that HC would notice I was a student even though I was a student I wasn't expected to do anything practical it was mainly self reflecting and also for the staff to get used to me being a student. Myself I felt nervous. The Health Carers were fabulous goading me on and saying I am doing a great job and we are all going to follow in your footsteps, there was a few nurses who was a little bit I don't know lets say I didn't feel comfortable with them but the Doctors and the consultants they were sort of doing a double take "Oh it's J, why has she got that top on". Luckily it started with Halloween so I said I've come dress up as a Halloween costume so that did that and after a while people did actually get used to me having a white top on. The only thing is when I came back as a HC it confuses people a bit its kind of Oh are a HC today or are you a student and that is kind of a little bit confusing. I'd like to carry on over the years to see how that changes because I will still carry on being an HCA through the 4 years uum and I think if I can probably write a piece to see if there is something that they can change in the system because I do think that it confuses staff.

Being a student is an area known never to debut

returning as HCA confused staff

I does it confuse you?

J cer not not really because I have kind of different hats on its weird how you do change into a student role and into a HC role. The HC role you feel a little bit that you are putting your comfortable slippers on because you know you haven't got that

should not confused re roles



## APPENDIX 4.14 YEAR GROUPS TENTATIVE IDEAS

### Yr 2 T2 LORA student

Wanting to do more with people  
Enjoyed HCA job  
Wanting to be a nurse  
Encouraged  
Concerned re age

Aware of service changes + bigger picture  
Further means not treated as supplementary  
Furthest difficulty - suddenly visible

Aware of nurse's shadowful role  
Feeling like a student nurse  
Wanting to be a nurse + to be a nurse team member  
HCA vs student role initially thought little different

Student role comes with high expectations to make  
out of comfort zone + to step up  
Team + responsibility of nurse + student  
Feeling terrified of making an error

Mentor supports taking up student role  
At placement + mentor facilitates change  
Intimidating + workshop - walk away with sense of too long a session

Constrained by family, research, pressure to complete  
Reading imperative for assignments  
Level of difficulty increases over time  
Tried staff unable to help  
Finding it a bit practice for assignments

Poor HCA experience raise doubts re capability  
Prior experience means staff are confident  
Age + experience counts with staff  
Using experience to be useful + full in time

HCA inexperience + used to initiation how clinical area  
Getting the back out of placement  
Sees factory as solution too busy mentor  
First placement feeling intimidated - keep head down

Motivation to be a nurse

HCA environment + culture

Understand role of nurse  
+ student

Moving from HCA to  
student role

Support for learning in CP

Academic Learning

Impact of HCA role on CP +  
Academic

Learning in CP

### Yr 2 T2 Class student

Enjoyed being HCA  
Wanting to do more  
Wanting a more rewardy job  
Encouraged by partner

Motivation to be a nurse

\* Takes charge of own learning  
\* Teaching an integral part of being a nurse  
\* changed poor mentor  
\* gaining skills, knowledge + understanding of pt care  
Good zone, upskilling knowledge, willing to teach  
Didn't understand fully role of nurse + student role in between

Understanding role of nurse  
+ student

The best change - absolutely brilliant  
Feeling good about developing a career  
Nervous knowing a lot to learn + having more responsibility  
Needing to leave HCA role + learn  
Basic care same - students do medications  
HCA modelled re the 2 roles  
The next ward I put myself forward  
\* Gaining skills, knowledge + understanding of pt care

Moving from HCA to  
student role

Mentor builds confidence, says experience is notable + suggests  
putting self forward  
Mentor willing to teach + guide  
Mentor encouraging + tests learning  
Becomes poor mentor + takes charge of own learning  
Mentor did not want to teach + role of nurse  
changed poor mentor

Support for learning in  
CP

First day activities  
Previous skills captured, validated + confidence increased  
Prior learning helps with assignments + academic skills  
Reading up  
Academic confidence high at beginning than clinical  
Presentations organised, not panicking

Academic Learning

Experience helps confidence in first placement  
Continuing (placement) now + took time to understand + build  
First step on being gained before learning but confidence  
Would still be able to find points - just harder to find

Impact of HCA  
CP + Academic

First placement loved + a lot to learn  
Yr 2 understanding the situation, calm under stress, talk to family  
Friends about the knowledge needed  
Being pushed increases competence + feels good

Learning in CP

## APPENDIX 4.15

### MATRIX TO IDENTIFY CODES AND CATEGORIES

#### Matrix to identify codes and categories (adapted from Smith & Firth 2011)

Aim: To understand the work role transition to Registered Nurse of student nurses who were formerly employed as Health Care Assistants

Objectives:

1. Explain students' experiences of the transition process
2. Explore the impact of work role transitions on students
3. Identify and discuss the facilitators and constraints to transition from Health Care Assistant to Registered Nurse
4. Develop a model to explain the transition from Health Care Assistant to Registered Nurse.

INTERVIEW TRANSCRIPT QUOTE	DESCRIPTION (in-vivo codes)	PRELIMINARY THOUGHTS (what is this about?)	INITIAL CATEGORIES
<b>Year 1 Time 1 (6 months post start) Castleton student [2yrs 6 months as an HCA]</b>			
<p>"Although I enjoyed the job I couldn't stand the company...no travelling time so everyone we saw had their time cut short... the nursing home.... very institutionalised...the nurses there were either particularly good in my opinion or particularly bad and carers as well"</p> <p>"Well one of the nurses I didn't like the way she paced and I thought if she can do this and get away with treating people like this and academically she can do this and if she can so can I"</p>	<p>"no time"</p> <p>"very institutionalised"</p> <p>"if she can so can I"</p>	<p>Enjoying the job</p> <p>Seeing problems and solutions</p> <p>Confidence to apply to be a nurse</p>	<p>Motivation to be a nurse</p>

<p>“Essay writing I am useless.... I don’t feel academically I am particularly good but then on practice nurses all telling me that I am brilliant.... I am not confident that I am going to be able to get the grades”</p> <p>“people are sitting in their own little groups....it drives me potty when there are youngsters... you know they sit at the back.... I feel I am much older and don’t learn as quickly... no yea its still a bit daunting and yet when it comes to practice I feel much more at home”</p> <p>“we have theory one week, practice the next and a good 8-10 weeks before I practice and got it done”</p> <p>“I have certainly got past the point of asking in front of 50 people am I going to make an idiot of myself I will just ask”</p> <p>Sociology, why do I need to listen to this and I struggle with psychology and the health promotion and the biology obviously. That’s great”</p> <p>“I go to the digital library”</p>	<p>“academically...not confident able to get the grades”</p> <p>“on placement telling me I am brilliant”</p> <p>“I am older and don’t learn as quickly.... When it comes to practice I feel much more at home”</p> <p>“I will just ask”</p> <p>“I struggle”</p>	<p>Academic confidence low</p> <p>Clinical vs practice confidence</p> <p>Fears re age</p> <p>Demonstrating confidence in uni</p> <p>Academic struggles and unable to relate theory to practice</p>	<p>Academic confidence and experience</p>
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<p>“the placement I was on had several emergencies...they couldn’t get the tube down and the stethoscope was missing...so rushing out into the corridor there happened to be a registrar there.. nearly knocked the registrar out with his own stethoscope ...I wanted to cry because pure frustration because I didn’t know enough and I didn’t know what a laryngoscope was and they could have done it quicker...I got teary when I got home”</p> <p>“the man not passing the urine I do think it was the health care experience that helped as opposed to the university”</p> <p>“making sure they have everything they need that they can reach”</p> <p>“with the elderly with dementia that helps moving and handling and that sort of thing”</p> <p>“the sister on the ward said you have definitely got a confidence about you on the ward that I’m not seeing in the others yet....there are times when I do and times when I don’t”</p>	<p>“frustration because I didn’t know enough”</p> <p>“health care experience that helped”</p> <p>“sister said you have confidence... times when I don’t”</p>	<p>Not knowing enough</p> <p>Having background as an HCA helpful</p> <p>Doubting own confidence</p>	<p>Practice experiences</p>
<p>“when we was on placement because we had to work with those other little groups and</p>	<p>“we had to work with other groups”</p>	<p>Working with others</p>	<p>Being a university student</p>

<p>we come back for four weeks the atmosphere was a lot more relaxed”</p> <p>“I’ve got children... the university is very much it is nothing to do with us”</p> <p>“my bursary pays my childcare ...I am banking to try to support myself and the kids”</p>	<p>“childcare problems”</p>	<p>Childcare problems</p>	
<p>“our very first day a lot of confused trying to get all our passes”</p> <p>“quite daunting... I think because I thought I would be one of the eldest ones. I wasn’t the oldest there which made me feel more comfortable”</p> <p>“So yes it was quite daunting day at the time um now I look back it wasn’t that daunting but on that first day I just thought oh my God what have I done”</p> <p>“I have learnt loads ... if I had my way I would completely change the way that they teach nurses, more practice more than being in the university”</p>	<p>“first day confusion”</p> <p>“daunting ... I thought I would be one of the eldest”</p> <p>“now I look back it wasn’t that daunting”</p> <p>“oh my God what have I done”</p> <p>“have learnt loads...if I had my way I’d change the way they teach”</p>	<p>Initial feelings re changing roles</p> <p>Concerns re age</p> <p>Finding learning tough</p>	
<p>“Do you want to go down and see a scan and out of the corner of my eye I can see somebody he needs a commode... and I really do want to go and see that and I do find myself torn quite often....I come down on the nursing, what I need</p>	<p>“I do find myself torn quite often...I come down on what I need to learn”</p>	<p>Stepping back from the HCA role</p>	<p>Understanding the role of the student vs HCA role</p>



<p>to learn ”</p> <p>“at the nursing home I do find myself wanting to do more nurse things... When I work at the hospital the HCAs are doing a lot of what the student nurses do anyway... the one thing we do as students that the HCA don’t do is that we assist in medications and injections.. so long as we have our mentor with us or qualified staff”</p> <p>“a doctor doing a male catheterisation and you know she was quite persisted you know the nurse is here and it will be fine and I said I’m not going to do it and I didn’t”</p> <p>“when I am working as a student nurse I’m working differently than when I have got my HCA hat on...I’ve got my thinking hat on... when I have got my HCA hat on I’m more task orientated”</p> <p>“I did not realise exactly how much a nurses a) had to do and how much they are responsible for. Responsibility has really hit home”</p> <p>“I had a very narrow view of nursing, you know a bit about health promotion, perhaps giving enemas suppositories and basically being a doctor’s</p>	<p>“the one thing we do as students that the HCA don’t do is that we assist in medications”</p> <p>“I said I’m not going to do it and I didn’t”</p> <p>“when I have got my HCA hat on” “my thinking hat”</p> <p>“responsibility has really hit home”</p> <p>“a narrow view of nursing”</p>	<p>A limited view of nursing</p> <p>Understanding boundaries</p> <p>HCA role task orientated, student role a thinking one</p> <p>Responsibility awareness hits home</p> <p>A limited view of nursing being revised</p>	
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<p>dogsboddy... I didn't realise the responsibility... they don't necessarily do what the doctor says"</p> <p>"They all say the first six months was the most terrifying thing they have ever done....Absolutely terrified... I am terrified of not having the skills to do the job....qualified staff made a mistake she said IV drugs and I said Oh God that terrifies me"</p>	<p>"Absolutely terrified"</p>	<p>Terrified about nurses' responsibilities</p>	
<p>"as soon as you say you are a student the doctors are very open to help you learn"</p> <p>"support workers are very important because you know they have a lot of experience and just the basics"</p> <p>"I read quite a bit. I drive my husband potty... telly documentaries and thing to do with the NHS , nursing emergency biker that's another"</p> <p>"read patient notes. Go around with doctors on rounds... talk to radiographers...literature on the ward is poor...often pick up patient literature, I have made friends with the dieticians"</p> <p>"qualified nurses say here's my portfolio do you want to look...but no thanks...I don't want</p>	<p>"the doctors are very open to help you learn"</p> <p>"support workers are very important"</p> <p>"Read. Husband... telly documentaries"</p> <p>"Patient notes/doctor/radiographer/ward literature/dieticians"</p>	<p>Doctors help and teach</p> <p>Support workers utilised</p> <p>Family support &amp;TV</p> <p>Practitioner support Patient support Literature</p> <p>Concerns re learning boundaries</p>	<p>Learning support</p>

<p>to get the wrong end of the stick and the whole plagiarism thing”</p> <p>“In a very nice way...If I did something wrong my mentor would make sure she showed me the way that it should be done but in such a way I never felt oh my God I am going to get myself into trouble”</p>	<p>“plagiarism”</p> <p>“in a very nice way...my mentor showed me the way”</p>	<p>Mentor support good</p>	
<p>“experienced nurses have found junior nurses on that shift and say “Oh for God’s sake”</p> <p>“and if apply for a job they will remember me and just sort of be on the ball”</p> <p>“they write everything down or someone was going to accuse them of doing the wrong thing”</p>	<p>“experienced nurses /junior nurses....Oh for God’s sake”</p> <p>“I want to be remembered as a good student”</p> <p>“someone was going to accuse them”</p>	<p>Experienced nurses are unsupportive</p> <p>Looking to the future</p> <p>A blame culture</p>	<p>Culture in practice</p>

CLINICAL HISTORY

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## **APPENDIX 4.17**

### **INITIAL CATEGORIES TO CREATE A CHART**

1. MOTIVATION TO BE A NURSE
2. MOVING FROM HCA ROLE TO STUDENT NURSE ROLE
3. LEARNING SUPPORT AND CONSTRAINTS IN CLINICAL PRACTICE
4. ACADEMIC LEARNING
5. ACADEMIC SUPPORT AND CONSTRAINTS
6. CHANGING SELF
7. UNDERSTANDING THE ROLE OF THE RN
8. IMPACT OF PRIOR HCA EXPERIENCE ON BEING A STUDENT IN CLINICAL PRACTICE
9. IMPACT OF PRIOR HCA EXPERIENCE ON ACADEMIC LEARNING
10. THE HEALTH CARE CULTURE AND ENVIRONMENT

TAKEN FROM:

**T1 Y1:** MOTIVATION; ACADEMIC CONFIDENCE AND EXPERIENCE; BEING A UNIVERSITY STUDENT; UNDERSTANDING HCA vs STUDENT ROLE; UNDERSTANDING THE RN ROLE; LEARNING SUPPORT; CULTURE IN PRACTICE AND UNIVERSITY

**T2 Y1:** MOTIVATION TO BE A NURSE; UNDERSTANDING THE HCA VS STUDENT ROLE; TRAINING AND TEACHING AND LEARNING; FEELINGS AND PERCEPTIONS OF BEING A STUDENT NURSE; CULTURE OF THE NHS AND UNIVERSITY; RN ROLE

**T1 Y2:** MOTIVATION TO BE A NURSE; THE EXPERIENCE AND JOURNEY OF PERSONAL CHANGE; THE HEALTH CARE ENVIRONMENT; TAKING UP THE STUDENT ROLE IN CLINICAL PRACTICE; IMPACT OF PAST HCA EXPERIENCE; ACADEMIC LEARNING; HCA VS STUDENT ROLE

**T2 Y2:** MOTIVATION TO BE A NURSE; MOVING FROM HCA TO STUDENT; BEING A STUDENT IN CLINICAL PRACTICE; ACADEMIC LEARNING; CHANGE IN SELF; UNDERSTANDING THE ROLE OF THE RN; IMPACT OF PRIOR EXPERIENCE ON LEARNING IN CLINICAL PRACTICE

**T1 Y3:** MOTIVATION TO BE A NURSE; IMPACT OF PRIOR EXPERIENCE IN CLINICAL PRACTICE; ACADEMIC LEARNING; CHANGING UNDERSTANDING OF ROLES; THE NHS CULTURE; LEARNING TO BE A NURSE; PAST EXPERIENCE IMPACT

**T2 Y3:** MOTIVATION TO BE A NURSE; IMPACT OF PRIOR HCA EXPERIENCE IN CLINICAL PRACTICE; LEARNING SUPPORT IN CLINICAL PRACTICE; STUDENT PERCEPTIONS OF CHANGING SELF; HCA VS STUDENT ROLE; IMPACT OF PRIOR EXPERIENCE ON ACADEMIC DEVELOPMENT; ACADEMIC SUPPORT AND CONSTRAINTS

## APPENDIX 4.18

### THEMES AND CATEGORIES LINKED TO THEORY

Re-refining themes and categories (August 18 2013)

From HCA to Registered Nurse.

INITIAL THEMES	RE-REFINED THEMES	Categories	Theories which can illuminate and help explain the data
	<p>STEPPING UP</p> <p>A core theme which runs across the analysis</p> <p>The 10 themes group into 3 overarching themes: clinical practice, academic achievement and role awareness.</p>		<p>TRANSITION THEORY</p> <p>Nicolson &amp; West 1989: Transitions, work histories and careers.</p> <p>Preparation-&gt; Encounter-&gt; Adjustment-&gt; Stabilization-&gt;Preparation</p> <p>SOCIALISATION</p> <p>Goffman 1959: The presentation of self in everyday life.</p> <p>Theatrical performance; the way in which the individual in ordinary work situations presents himself and his activity to others-controlling impressions and the things he may or may not do to sustain his performance</p>
<p>1 Motivation to be a nurse</p> <p>2 Moving from HCA to student nurse</p>		<p>SUBCATEGORIES (1) BEFORE PRNP</p> <p>(2) DURING PRNP</p> <p>Yr1 T1 OU student:</p> <p>(1) Enjoys HCA role; no prospect of career progression; thirsty for</p>	<p>Maslow's hierarchy of needs.</p> <p>Intrinsic and extrinsic motivation: associated with achieving a goal or performing a task for its own sake vs desire for reward (Benabou and Tirole 2005)</p>

3 Learning support and constraints in clinical practice		knowledge; wanting more responsibility; early financial constraints blocked progress; long term ambition	Lave & Wenger 1991: communities of practice and legitimate peripheral participation: a way of understanding learning based on situated negotiation and renegotiation of meaning; encompasses apprentices, young masters with apprentices and masters
4 Academic learning support and constraints		Yr1 T1 Beds student: (1) Enjoyed HCA role: sees probs in practice and possible solutions; poor RNs give confidence	
5 The journey and personal change		standard is attainable; (2) childcare problems; fears age is a constraint	
6 Understanding the role of the student and the RN		Yr1 T2 Beds student: (1) HCA role not something particularly wanted to do but really enjoyed it; could see faults in existing practice; thought you had to be super intelligent to be a nurse; encouraged by a student nurse; (2) childcare difficult; hugely committed and needs	
7 Impact of HCA experience on clinical practice		whole family support; fears can't cope domestically; every single penny of bursary goes on childcare	
8 Impact of HCA experience on academic progress		Yr1 T2 OU student	
9 Health care culture and		(1) Enjoyed HCA job; saw poor management; wanting to know	





		<p>by partner; (2) the best change absolutely brilliant; feeling good about developing a career; being organised and confident overflows into personal life(<i>might be better in the "Feeling Different" theme</i>)</p> <p>Yr3 T2 Beds student</p> <p>(1) Problems in old role as med student; likes breadth of nurse's role, patient contact, no pressure to advance career wise, and physical work; prior experience as HCA good - know what you are getting into; (2) I have got the job I want</p> <p>Yr3 T2 Beds student:</p> <p>(2) Enjoyed the journey; relieved to have successfully completed; hard work has paid off and now gives best quality care (<i>also fits the "Feeling different" theme</i>)</p>	<p>Melia suggests students learn to be students and not a nurse but we cannot be sure exactly what the role of the RN is (especially in 2013).</p>
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## **APPENDIX 4.19**

### **CENTRAL CHART**

#### **(6.2) Theme One: Wanting to be a nurse**

Motivators, risks, assumptions

- i) Getting started
- ii) Keeping going

#### **(6.3) Theme Two: The practice milieu**

Front and back stage regions

- i) Transferability
- ii) Staff support

#### **(6.4) Theme Three: Past and future roles**

Changed perceptions; roles and vistas

- i) The HCA role
- ii) The Registered Nurse role

#### **(6.5) Theme Four: Embracing the clinical role**

Feeling like a student

- i) Convincing performances:
  - Performing confidently
  - Developing a knowledge base
- ii) The impact of HCA work experience:
  - Expectations
  - Bad habits
  - Sliding back
  - Wearing two hats

#### **(6.6) Theme Five: Academic status change**

Performing academically

- i) Prior qualifications
- ii) Performing to required standards
- iii) Linking theory to practice
- iv) Strategies for learning
- v) Personal change

**APPENDIX 4.20**  
**FRAMEWORK MATRIX – THEME 1 YEAR 1**  
**THEME ONE: MOTIVATION**

<b>PARTICIPANTS</b>	<b>1 MOTIVATION [O1]</b>	<b>1.1 GAINING ENTRY [O2,3,4]</b>	<b>1.2 KEEPING GOING [O3,4]</b>	<b>NOTES</b>
<b>CASTLETON UNIVERSITY</b>				
Y1 T1 John	Knew he wanted to be a nurse	Became HCA to make sure correct career choice, to provide experience & help gain entry to nursing. Felt “elated” when accepted & “first step of his future”. Believed HCA experience would “absolutely” help	Looks forward to qualifying but worried about responsibilities/accountability	Motivation is a theme that is a bit more analytical and a bit more specific than previous title “Wanting to be a nurse”
Y1 T1 Mike	Had seen registered nurses perform “absolute miracles” with patients (eg resuscitation) and wanted to be able to do the same. Enjoyed HCA role. Time to move on	Worried about “keeping up” academically because had been out of full time education for a long time. “Excited” once accepted	“you have to love each patient” Feels “busy, busy, busy” - whole year planned out with academic and practice work and assessments	Emotions play a big part in the transition process
Y1 T1 Anna	Enjoyed HCA work but hated working for the private agency providing care feeling clients short changed and care home “institutionalised” - but superficially “they looked clean & beautiful”. Some RN care very poor- felt could do better		“terrified” at prospect on being an RN , more determined than at beginning, terrified of the first 6months of being an RN; new graduates say it’s the most terrifying thing they have ever done bar none	The fear factor drives student learning

<b>LOMBARD UNIVERSITY</b>				
Y1 T1 Helen	Bored with HCA work. Enjoyed "learning more"	Left school at 13 to look after mentally ill mother. Managed to gain NVQ L3 and passed key skills test in maths and English	Frightened of being accountable and of the responsibilities of the RN	Fear of RN responsibilities a key thread
Y1 T1 Steve	Career progression and to give "proper" care	Had been trying to gain entry for 11 years and finally accepted at U of DL. Actively discouraged by father. So excited cried when accepted	No time for socialising, sometimes feels down but determined to keep going	Some students go to extraordinary lengths to gain entry. Pressure can be external eg father discouragement
Y1 T1 Jill	Had progressed as far as possible as an HCA. Enjoyed HCA work. Wanted underpinning knowledge not "just going in and doing the job"	Completed NVQ level 3 "opened the flood gate for knowledge". Went on as many free in house courses as possible. Until line manager changed was not supported to apply and receive secondment	U of DL students have to be more motivated and do more than traditional students	Secondment is a particular issue for U of DL students who need this to enter the PRNP
<b>CASTLETON UNIVERSITY</b>				
Y1 T2 Sally		Struggled to gain entry because of numeracy criteria but stuck at it to gain the necessary qualification	Finds course more very stressful. Had a "wobble" when friend left due to stressful nature of the course. Worried about failure. Hard work, tiring & family have all needed to adjust , but a "good move"	Numeracy seems to be a problem for former HCA. Look out for this in theme 5  Students with families struggle to cope
Y1 T2 Annya	Became an HCA because of convenience but enjoyed it AND felt could	Encouraged by qualified nurse and went to learn direct to gain numeracy	When on ward goes at it "150%" and arranges additional child care to	Keep an eye out for academic quals - maybe this group very generally have

	do a better job than some qualified nurses who had a bad attitude to patients - felt could do better	qualification. "Petrified" of academic side "oh God what have I done"	enable more time in practice; involves a "nightmare" whereby family, friends and child carers are all needed and all bursary money goes on childcare. The course takes over life. Husband says she is very stressed & "can't wait for this bloody course to be over". Holiday times prescribed so unable to book at cheap times	low quals. Survey will show if this is the case  Time and money can be an issue
Y1 T2 Joan	Always wanted to be a nurse	Gained entry then applied to be an HCA to gain experience. Watching other nurses confirmed career choice	Worried about hospital placements coming from a community HCA work role but determined to finish. CFP finished "yesterday" and time has flown by. Was attacked by a pt in LD home but went to another & "was glad I went because I had become frightened"	Former work setting has an impact on experiences of placements. Prior experience did not help prevent being attacked
<b>LOMBARD UNIVERSITY</b>				
Y1 T2 Mary	Bored in the HCA role, wanted to understand rationale for care. Something always wanted to do	DL part time course enabled entry - able to balance home and work life commitments	Overwhelming experience but enjoyable "so will get there"	More evidence of the high emotions involved in the transition

Y1 T2 Janet	Interested in what nurses and CNS do	Left school at 16, very worried about academic work	Burst into tears when heard passed CFP. Husband, children and parents all very supportive	
Y1 T2 Lizzie	Admired nurses commitment to their work, wanted to do good with her life, seeing father nursed when he was terminally ill. Enjoyed HCA work but wanted to do more	Father with terminally ill cancer died v. shortly after Lizzie showed him letter of acceptance to PRNP	Terrified at the thought of the responsibilities incurred when becoming a registered nurse but none the less looking forward to it. It's a "commitment for all your life- everything in your life changes" A long way to go	Maybe there is something here about a core theme which is about moving away from "just doing a job" to being a different sort of worker – committed - a professional?

## APPENDIX 4.21

### FRAMEWORK MATRIX – THEME 1 YEAR 2

#### THEME ONE: MOTIVATION Y2

PARTICIPANTS	1 MOTIVATION	1.1 GAINING ENTRY	1.2 KEEPING GOING	NOTES
<b>CASTLETON UNIVERSITY</b>				
Y2 T1 Annil	Wanted to be a nurse since childhood. Both parents nurses “that was a blessed factor to follow in their footsteps”			The old fashioned idea of vocation seems strong in former HCA. Was also present in Y1 students
Y2 T1 Cath	Always wanted to be a nurse. Surrounded herself with nurses and health care until in a position to train		As course expectations increased became upset went to doctors and first placement dented confidence- seriously considered leaving. Since has managed to “get everything done” and “pressure keeps me going”. Good days on placement give a real boost “I can do this- this is what I came to do...I feel I am nearly there”. Other times feels daunted and worried about becoming an RN. Fellow student has become best friend without whom would not get through. Feels de-motivated when no classes for a couple of months	1.2 Evidence of student learning to cope with course pressures by start of Y2  Peer group important for keeping going

Y2 T1 Brenda	Wanted a career and wanted children to be proud of her career. Wanted to know more	Worked around the hospital as HCA to gain wide experience to assist in application to nursing	Not as motivated now as at beginning, not to do with placements but with uni	
<b>LOMBARD UNIVERSITY</b>				
Y2 T1 May	"Obviously" something had always wanted to do	First did an OU HE level 1 course in H&S Care - enjoyed it so decided to do GCSE Maths - enjoyed it - decided to do GCSE English - didn't enjoy it but gained a good pass. Passed to interview panel "and to me" I could do it. "Wonderful" day when accepted. Mum went and put hand through letterbox to retrieve the letter; work colleagues celebrated	Extreme family problems arose at beginning of course - "I didn't tell the university I just struggled on". Is sure has a lot more to learn but is excited about the future. Peer "best friend" who has just completed PRNP - provide mutual support - talk to and confide in one another	
Y2 T1 David	Enjoyed HCA work "extremely" & encouraged to progress by NVQ tutor and ward sister	Felt "overjoyed" at gaining entry "like it's summat what I want to do"	Now feels more confident and competent. Enjoying the course - "I love what I am doing - not one day goes by when I don't want to go to work". Excited about becoming a registrant	
Y2 T1 Vicky	Pressured by parents at 16 to get a job and settle down. Later did HCA job which really enjoyed. Decided to give nursing "a go...I'll either get into it or find it too difficult but at least have given it a go". A	Did Btec in H&S Care. Felt nervous and sick and relieved on gaining acceptance	From discussions with other members of cohort all have thought of leaving at some time during the first year. Finding it hard to study especially when on placement and fit in domestic needs "in the	More evidence of the great emotions involved in the transition I think students really, really want to be a nurse and successfully pass the course. I made a note that Vicky sounded distressed when recalling



	career that's transferable around the world. Secondment makes training viable		second year many students face a reality". Sets mini targets - "it's the only way". Angry it's not a mainstream uni thinking "at least they have a life" but supposes the courses are similar in content. Needs great motivation to progress	feelings when accepted. Evidence of Van Gennep's stage 2 "no man's land"
<b>CASTLETON UNIVERSITY</b>				
Y2 T2 Annil			Had to retake a unit in order to progress to yr2 First placement revisited at end of y1 - was "brilliant" mentors v supportive and learnt many skills. Progression evident to staff and to A Has visited theatres many times. Likes the care and feels "that is the right place for me to go ". Found Y2 "very hard time for us"	
Y2 T2 Susan	Did foundation degree and took job on wards to fund further studies - "made me happy" - decided to make it a career	Did as much HCA work as possible to gain experience before entry to PRNP. Nervous but excited on acceptance	Scared but exhilarated at the prospect of being an RN in a year's time and of not knowing where will be working	
Y2 T2 Kim	Enjoyed being an HCA, wanted to do more, felt nursing was the next career step. Partner encouraged and "pushed".	Day one remembers felt nervous at responsibilities to come but very determined to continue to end. Felt had a lot to learn.	Seeing RN go the extra mile and willing to teach increased determination to succeed. Excited at the prospect of becoming an RN	

LOMBARD UNIVERSITY				
Y2 T2 Anita	Worked as an agency HCA for "good money" following being restaurant manager. Loved being an HCA & wanted to be a nurse. Encouraged by staff and by friend who went to train as a paramedic at 39 yrs old & saw others doing similar HC professional training	Long haul to gain entry - 4 years. Each time applied local uni raised entry quals. When gained a place at UoDL "I was just over the moon". Was daunted at the prospect of working in a constantly changing NHS in a stressful RN role. More confidence about own academic and practice abilities	"terrifying"- prospect of being an RN who can make a mistake due to "human error" Wants to make a difference in practice and is frustrated that at present she is not listened to re improvements "want to influence and change where things can be better managed"	Ageism exists in people's minds and is powerful
Y2 T2 Amanda	Always wanted to be a nurse. Pregnancy precluded. Secondment the only viable option. Gained NVQ level 4 but was not paid for additional learning so left job. Gained secondment at next job	Spent a year gaining English and Maths entry qualifications. Felt "honoured" when accepted - didn't expect I t- couldn't turn it down regardless of how might cope. Scared. Proud and terrified at first, worried about ability to learn	Has coped with course "as it turns out ... quite well"	Theme of UoDL students is that without secondment training would not be a viable option
Y2 T2 Veronica	Wanted to understand more of student journey. Felt prepared to "give it a shot" and if fails then so be it - have tried.	Mixed emotions on acceptance "pleased" and at age 35 "oh my god what have I done" "it feels like you are not a blank canvas you have got some sort of background to work on"		Ageism again!

## APPENDIX 4.22

### FRAMEWORK MATRIX – THEME 1 YEAR 3

#### THEME ONE: MOTIVATION Y3

PARTICIPANTS	1 MOTIVATION	1.1 GAINING ENTRY	1.2 KEEPING GOING	NOTES
<b>CASTLETON UNIVERSITY</b>				
Y3 T1 Moyra	Worked as an HCA when doing a degree and really enjoyed it and “knew” it was what she would be happy doing		Feels bogged down with many assessments to complete before end of programme. Once back on placement feels will be able to see the end. Had enjoyed every placement so not worried where staffs. Very excited at prospect of being an RN but nervous because aware a lot to learn	This student is getting ready for the next transition: to RN  Becker Boys in White p36 made me think that getting started is a long term perspective and keeping going a short term perspective
Y3 T1 Simone	Something always wanted to do and just a matter of time	Did an access course to gain entry	Have to be strong and determined to succeed as a student - “it is a task you just have to be strong. If you say you want to do this then you have to be determined”	
Y3 T1 Terry	Worked as an HCA then in office but dissatisfied with that, already had a degree, decided to move into nursing because found it rewarding and lots of scope within the RN role, and a good career		Is both looking forward to and fearing becoming a registrant taking of it as a risk that has to be taken	The prospect of a new role engenders the same feelings both positive and negative as at the start of the programme

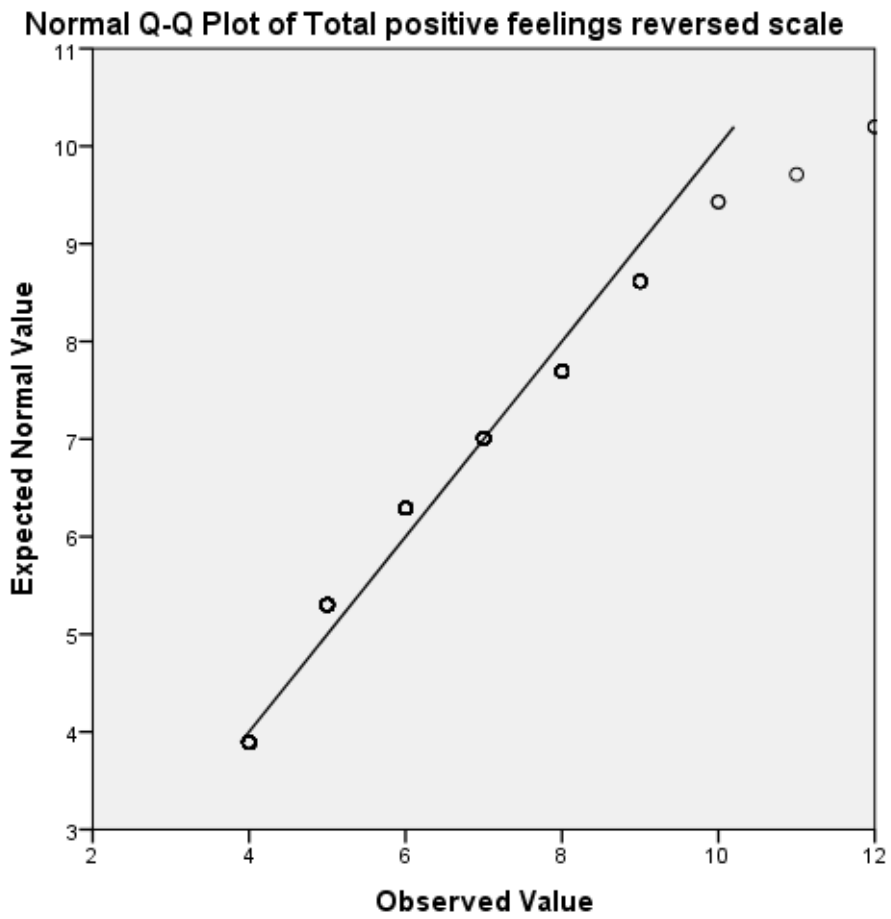
LOMBARD UNIVERSITY				
Y3 T1 Ruby	Worked as an HCA for 19 years, gained NVQ3 did not apply for nursing because of age. Then realised an opportunity to prove herself. Knew she could do more than HCA work and HCA work a dead end	Felt petrified and excited when accepted but enjoys challenges	Family have been very supportive and now daughter has graduated Ruby has gone on to this programme	This student talks of perspective change and I wonder if I should think a bit about Mezirow here?
Y3 T1 Tina		Excited when offered a place but apprehensive due to being knocked back by conventional uni	Friends and colleagues have been very supportive. Family have been really proud of her progress and that spurs her on along with love of the job. Marriage has broken up since course began. Now more confident at work and that feeds into home life as a virtuous circle "the knowledge that I have learnt well"	Confidence is linked to knowledge increase
Y3 T1 Dora	Always wanted to be a nurse but the opportunity never arose until now because of family commitments	At outset felt excited but very fearful of being able to cope academically	Fellow students are a big mutual support "all in it together". Determined to continue and only able to give 100% to academic work otherwise feels embarrassed. It is hard being a student and having other responsibilities and "a sponge for a brain"	Evidence here again of an adult learner very lacking in confidence and feeling she must give at least 100% all the time

CASTLETON UNIVERSITY				
Y3 T2 Marcus	Was a student for 3 years but failed an exam so re-entered at Beds with credit for 1 yr CFP only. Wanted more money, to do jobs to help himself and be a responsible person.		Focused on becoming a nurse. Failed Y3 exam but moved from London to Beds and kept going. Middle part of 5 years most difficult but since at Beds has felt more settled and life has improved	
Y3 T2 Bettina			Found working as an HCA plus management placement, dissertation and portfolio completion a very busy time at end of programme. Agency nurse gave feedback communication skills not good even though had not worked with her but B cried and carried on	
Y3 T2 Sharon	Started off training to be a medic but did HCA work and enjoyed it. Felt nursing gave more scope than medicine and greater chance of being effective. Felt like a robot as a medic but liked spending time with patients as an HCA. Could advance or not and be satisfied with the work. Needed something more testing than the HCA role much as liked it		Lot to complete in Y3 service user project and very tiring	

LOMBARD UNIVERSITY				
Y3 T2 Carol	Started training but left after 6 weeks to travel then became HCA. Became a band 4 and was accepted at UofDL at same time. When starts as an SN there will be no difference in pay due to overlapping pay scales. Needed to be an RN to support her family for money and for "security". Also wanted the knowledge and a new career		Peer group an important support  Juggling home and work and study is difficult	Interesting C sees the RN role as a new career
Y3 T2 Margaret	Always wanted to be a nurse. Started training but had to leave after a year because pregnant. Then worked as HCA in nurs. home then NHS		Family now grown up so feels able to do training but later states they have caused problems throughout	
Y3 T2 Tanya	Began studentship at 17 but left to have a baby and spent 21 yrs as an HCA. Had always wanted to be a nurse and secondment facilitated this. Being an HCA was not enough; wanted to do more	Had maths and English quals from school and did K100 (HE L1) to gain entry. Was very nervous when accepted having not completed before was very nervous about not completing this time around	Met another student and met at least once a week and supported one another throughout. Not a week passed without tears and threats of leaving but peer provided support. The course has been hard and has felt alone and isolated. Two family tragedies occurred but kept going with help of colleague/friend and could not face giving up twice	Isolation is a problem for Lombard students and not for Castleton students

## APPENDIX 5.1

### Q-Q PLOT POSITIVE FEELINGS



## APPENDIX 6.1

### CLINICAL AND PROFESSIONAL CONFIDENCE MEASURES: RELATIONSHIP WITH YEARS WORKED AS AN HCA; FORMER WORKPLACE; HOURS CONTINUING TO WORK AS AN HCA; FEELINGS (POSITIVE, NEGATIVE AND STRESS), BY TIME AND YEAR GROUPS

	Time 1 Year 1 F ratio (Sig) n <sup>2</sup>	Time 2 Year 1 F ratio (Sig) n <sup>2</sup>	Time 1 Year 2 F ratio (Sig) n <sup>2</sup>	Time 2 Year 2 F ratio (Sig) n <sup>2</sup>	Time 1 Year 3 F ratio (Sig) n <sup>2</sup>	Time 2 Year 3 F ratio (Sig) n <sup>2</sup>
<b>CLINICAL CONFIDENCE</b>						
Years worked as an HCA	.791 (.543) .121	1.081 (.414) .164	1.726 (.169) .182	1.654 (.195) .223	2.126 (.090) .138	1.467 (.227) .111
Former workplace	1.091 (.346) .051	1.001 (.999) .000	.305 (.739) .014	1.243 (.301) .068	1.296 (.280) .038	.156 (.865) .005
Continuing to work as an HCA	.619 (.652) .060	.058 (.944) .003	.133 (.969) .013	.768 (.554) .088	.828 (.513) .049	1.266 (.295) .061
Positive feelings	.640 (.697) .121	.969 (.456) .162	1.781 (.151) .248	2.452 (.057) .401	1.640 (.146) .187	.803 (.573) .101
Negative feelings	2.973 (.018) .426	.652 (.622) .115	1.100 (.391) .222	1.174 (.335) .243	1.355 (.239) .178	1.267 (.286) .191
Stress	3.503 (.044) .200	.612 (.550) .047	3.047 (.064) .184	.317 (.731) .028	1.299 (.282) .049	1.120 (.335) .050
<b>PROFESSIONAL CONFIDENCE</b>						
Years worked as an HCA	1.541 (.210) .156	.460 (.636) .027	.739 (.571) .067	.676 (.614) .078	1.244 (.301) .071	.184 (.907) .009
Former workplace	.353 (.705) .017	.936 (.402) .051	.735 (.477) .034	.396 (.676) .023	.121 (.886) .004	.102 (.904) .003
Continuing to work as an HCA	1.204 (.336) .173	1.047 (.407) .166	2.238 (.087) .219	1.491 (.238) .206	4.002 (.007) .232 [Levene test violated]	1/069 (.382) .186
Positive feelings	.350 (.904) .070	2.771 (.040) .357	.340 (.884) .057	4.509 (.004) .551	1.663 (.139) .186	.476 (.823) .186
Negative feelings	2.037 (.085) .337	.441 (.816) .081	.168 (.990) .040	1.032 (.431) .220	.628 (.750) .090	.653 (.729) .108
Stress	.414 (.665) .029	2.512 (.101) .167	1.598 (.220) .102	1.416 (.264) .114	.098 (.907) .004	.382 (.685) .017



## APPENDIX 6.2

### PARAMETER ESTIMATES: ACADEMIC CONFIDENCE RELATIONSHIP WITH THE CLINICAL LEARNING ENVIRONMENT

#### Parameter estimates

Dependent variable: Academic confidence

Time and Year combined	Parameter	B	Std. Error	t	Sig.	95% Confidence Interval		Partial Eta Squared
						Lower Bound	Upper Bound	
T1Y1	Intercept	56.091	2.079	26.981	.000	51.889	60.293	.948
	[q16Binned_mentsuper=1]	-3.091	2.825	-1.094	.280	-8.800	2.618	.029
	[q16Binned_mentsuper=2]	-6.565	2.612	-2.513	.016	-11.844	-1.285	.136
	[q16Binned_mentsuper=3]	0 <sup>a</sup>	.	.	.	.	.	.
T2Y1	Intercept	55.818	2.282	24.459	.000	51.180	60.456	.946
	[q16Binned_mentsuper=1]	-.104	3.660	-.028	.978	-7.541	7.333	.000
	[q16Binned_mentsuper=2]	-.344	2.868	-.120	.905	-6.172	5.483	.000
	[q16Binned_mentsuper=3]	0 <sup>a</sup>	.	.	.	.	.	.
T1Y2	Intercept	59.571	2.478	24.037	.000	54.566	64.576	.934
	[q16Binned_mentsuper=1]	-	2.845	-3.524	.001	-15.772	-4.280	.232
	[q16Binned_mentsuper=2]	10.026						
	[q16Binned_mentsuper=3]	-4.971	3.001	-1.656	.105	-11.033	1.090	.063
T2Y2	Intercept	55.333	2.308	23.977	.000	50.643	60.023	.944
	[q16Binned_mentsuper=1]	-6.000	2.919	-2.055	.048	-11.932	-.068	.111
	[q16Binned_mentsuper=2]	-.103	3.002	-.034	.973	-6.204	5.998	.000
	[q16Binned_mentsuper=3]	0 <sup>a</sup>	.	.	.	.	.	.
T1Y3	Intercept	56.435	1.569	35.963	.000	53.302	59.568	.951
	[q16Binned_mentsuper=1]	-2.535	2.301	-1.102	.275	-7.129	2.059	.018
	[q16Binned_mentsuper=2]	-2.550	2.154	-1.184	.241	-6.851	1.751	.021
	[q16Binned_mentsuper=3]	0 <sup>a</sup>	.	.	.	.	.	.
T2Y3	Intercept	61.040	1.109	55.060	.000	58.822	63.258	.981
	[q16Binned_mentsuper=1]	-2.135	1.641	-1.301	.198	-5.418	1.148	.028
	[q16Binned_mentsuper=2]	-2.040	1.775	-1.150	.255	-5.591	1.511	.022
	[q16Binned_mentsuper=3]	0 <sup>a</sup>	.	.	.	.	.	.

a. This parameter is set to zero because it is redundant.

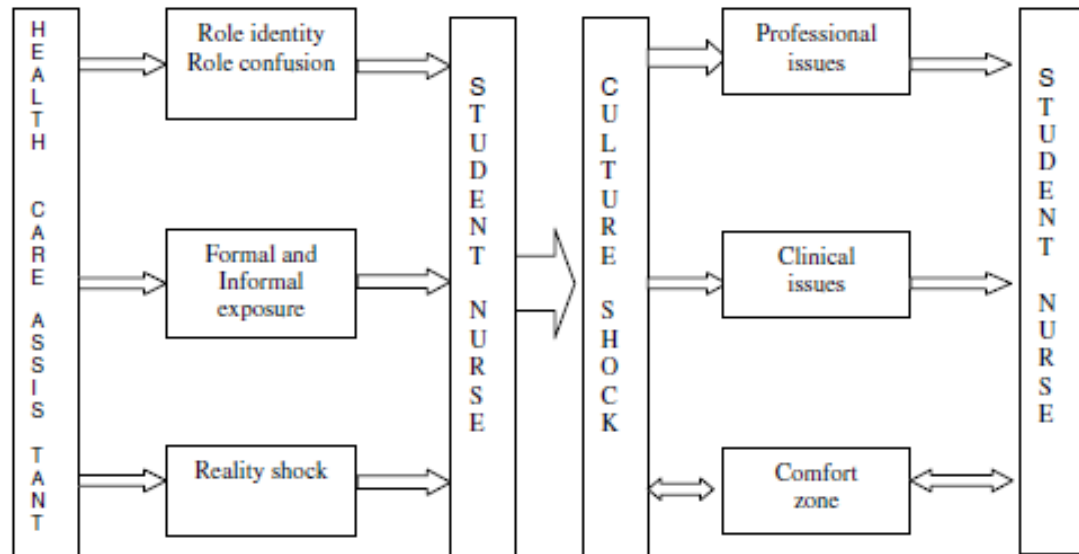
### APPENDIX 6.3

#### ACADEMIC CONFIDENCE MEASURE: RELATIONSHIP WITH YEARS WORKED AS AN HCA; FORMER WORKPLACE; HOURS CONTINUING TO WORK AS AN HCA AND FEELINGS (POSITIVE, NEGATIVE AND STRESS), ACROSS COHORTS

	Time 1 Year 1 F ratio (Sig) n <sup>2</sup>	Time 2 Year 1 F ratio (Sig) n <sup>2</sup>	Time 1 Year 2 F ratio (Sig) n <sup>2</sup>	Time 2 Year 2 F ratio (Sig) n <sup>2</sup>	Time 1 Year 3 F ratio (Sig) n <sup>2</sup>	Time 2 Year 3 F ratio (Sig) n <sup>2</sup>
<b>ACADEMIC CONFIDENCE</b>						
Years worked as an HCA	2.563 (.054).212	1.287 (.289) .072	.434 (.783) .043	1.015 (.414) .113	4.430 (.003) .200	1.433 (.242) .069
Former workplace	.150 (.861) .007	.903 (.415) .049	2.340 (.109) .102	3.066 (.060) .153	.384 (.683) .011	.291 (.749) .010
Continuing to work as an HCA	2.804 (.050) .328	2.279 (.095) .308	1.222 (.322) .136	1.350 (.432) .219	.430 (.786) .081	2.541 (.052) .178
Positive feelings	.834 (.812) .119	1.082 (.395) .178	1.282 (.302) .198	1.030 (.432) .219	2.661 (.020) .271 [Levene's test violated]	1.207 (.231) .144
Negative feelings	.519 (.812) .119	.876 (.511) .149	1.454 (.227) .281	.936 (.490) .203	1.760 (.108) .220	1.741 (.116) .245
Stress	1.013 (.377) .070	.702 (.505) .053	1.375 (.271) .096	1.916 (.171) .148	1.220 (.340) .042	4.312 (.020) .167

## APPENDIX 7.1

### THE TRANSITION PROCESS UNDERTAKEN BY THE HCA TURNED STUDENT



Source: Brennan G. & McSherry R. (2007) p. 213